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Report on
Montana State
Hospital, fiscal
year 1991

REPORT ON MONTANA STATE HOSPITAL

PREPARED BY THE MENTAL DISABILITIES

BOARD OF VISITORS

Fiscal Year 1991

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REPORT ON MONTANA STATE HOSPITAL

prepared by the

MENTAL DISABILITIES BOARD OF VISITORS

Fiscal Year 1991

This report of Montana State Hospital summarizes the findings of the Mental Disabilities Board of Visitors on-site review of the hospital. Section 53, Chapter 21, Part I, the Mental Commitment and Treatment Act, provides the statutory requirements for the delivery of mental health services.

During the review of the Warm Springs and Galen campuses, the Board and its seven consultants examined areas of treatment, record keeping, environmental conditions, medical issues and staffing. Information for this report is based on a review of randomly selected resident files, a review of the facility, direct observations and interviews with the residents, staff and administration.

The Board observed a number of positive changes since the last review. Recommendations made in this report are intended to provide direction, motivation and positive changes in Montana's mental health delivery system.

Mission of the State Hospital

Montana State Hospital is physically comprised of two campuses: the acute psychiatric inpatient unit located at Warm Springs and the intermediate care facility, acute care hospital and chemical dependency program located at Galen. Over the years Montana State Hospital has been expected to serve a wide variety of individuals. These include serving persons with a severe and persistent mental illness, developmental disabilities, head injuries, criminal court orders for evaluation and treatment, drug and alcohol addictions, sex offenders, personality disorders, elderly, and emphysema and other related lung disorders etc. A number of patients are being admitted, or have been admitted and remain at the state hospital, who would not be admitted to the vast majority of state hospitals throughout the country. These admissions are both voluntary admissions, involuntary commitments and sentenced by the court.

When the hospital takes on a variety of roles and purposes, its mission gets diluted. The competing roles and competing purposes begin to contradict one another and it becomes difficult for staff, patients, committing courts, the public and the legislature to sort out the role and mission of the facility. The Board does not see any way the current resources of the hospital can be used to adequately and effectively address the all of the multiple problems that exist.

The Board of Visitors believes that the state hospital will continue to play a critical role within the mental health system.

The state hospital and the Department of Institutions must address, however, the role and mission of a state-run inpatient psychiatric program and its role for the years 1990-2000 and the future. Such efforts will help clarify and provide direction for a number of related recommendations in staffing areas, treatment related matters, admissions and discharges.

Recommendations:

1. A clear definition and role for the state hospital in the next decade needs to be developed. A mission statement needs to be developed which addresses the hospital's purpose and the population to be served. Such a process must include, but is not limited to, reviewing existing policies such as the mission and admission criteria, Montana statutes, the state mental health plan and the report of the Consultants for Community Change. Input should be solicited from consumers, staff, community mental health centers, family members, advocates, mental health advisory committees, and mental health professionals.

2. Hospital committees need to be established to evaluate the mission statement, program and consumer needs of an inpatient program. In addition, a clear vision of the intended treatment outcome must to be coordinated hospital-wide and subsequently coordinated and developed for each treatment unit.

3. The hospital should review the mission of each treatment unit. Moreover, the hospital needs to examine those aspects of treatment units which are successful in order to determine the

principles that are transferrable to other treatment units. Success needs to be measured by the level of active treatment and the ability of patients to progress through the unit system to the community.

As documented in this report, there are some units which are operating well, others are in the process of evaluation and/or change. All of the changes appears to be occurring in isolation and independent of the other units. A well coordinated hospital-wide effort must be built and directed to provide a structured, goal directed treatment program for persons with severe and persistent mental illnesses.

4. With modifications and revisions to the mission statement, admission and discharge policies etc., it will be necessary to educate all the various judicial systems, other inpatient psychiatric units, mental health professionals, family members, consumers and community mental health centers on the mission of Montana State Hospital, and the admissions and treatment criteria used by the state hospital.

5. The Board urges the hospital to become accredited by the Joint Commission on the Accreditation of Health Care Organizations. Currently at least eighty per cent (80%) of state hospitals are accredited and are not spending more money in their operations than Montana. Staff must begin to think more about the development and implementation of treatment programs with existing resources.

ADMISSIONS, PLACEMENTS AND DISCHARGES

Statistics provided by the staff for calendar year 1989 indicate that 20% of the admissions were inappropriate while projections for calendar year 1990 estimated that only 5.2% of the admissions were inappropriate. Continued collection and monitoring of these statistics is important for the hospital as they evaluate and define their mission in the mental health delivery system. The Board suggests that involuntary admissions, including criminal sentences, be individually assessed for appropriateness rather than considering all such admissions as appropriate, which is the current practice.

The table below was excerpted from the intake unit statistics: (See Appendix A for related statistics)

	'89	'90 (Projected)
# of Admissions	618	614
% of 1st Admits	38%	41%
% of Re-Admits	61%	59%
% of Transient Admits	5.3%	4.3%
% of IHS Admits	1-2%	1-2%
% of Borderline Intell/MR	3.5%	3.5%
% of Personality Disorder	38%	36%
% of Drug & Alcohol	48%	39%
% of Inappropriate Admits	20%	5.2%

The total number of admissions appears consistent over this two year period. When comparing other public mental health systems to Montana State Hospital, we find the following:

National average number of public inpatient psychiatric beds per 100,000 (1985) (all populations/age groups)	65.2
Montana State Hospital number of beds and staffed (403) per 100,000 (includes forensics, no adolescents)	57.8

Wisconsin number of public psychiatric beds (includes adolescents and forensics)	24.2
Vermont number of public psychiatric beds (includes forensics, no adolescents)	16.0

Montana currently is slightly under the national average number of public psychiatric hospital beds available, however Montana State Hospital beds make no allowance for children's psychiatric beds. Current utilization of those beds is approximately seventy-five percent (75%), with an average daily census in the range of 270-310.

Other state systems (Wisconsin and Vermont) which have made major strides in reducing hospitalization and increasing the capacity of community programs have achieved a reduced number of inpatient psychiatric beds. An assertive approach by the State to improve the mental health delivery system, coupled with a mission statement and improved admission processes to the state hospital, must examine the number of public inpatient beds that are needed for Montana. Based on current public inpatient trends and Montana's population, the Board's consultants identified a need for approximately one hundred twenty to one hundred fifty (120-150) state-run psychiatric inpatient beds. This is supported by an analysis of the rate of usage of the state hospital by patients from the five community mental health regions in the state. See Appendix A.

Comparative data of the sixteen Western States gather by WICHE (Western Interstate Commission for Higher Education) in cooperation

with the Western Psychiatric State Hospital Association should also be compared in order to provide a regional comparative base for Montana. In addition outpatient community trends must also be examined.

The ratio of re-admissions to first time admissions reflects directly the unevenness of alternative services/community support programs statewide. Many comments were made by treatment unit staff that patients are discharged but re-admitted because they became unstable in their community placements. Many of the recurrent crisis situations which result in re-hospitalization of patients can and should be dealt with in community settings. The pattern of recycling patients in and out of the state hospital is predictable unless there is an assertive effort to engage persons in community programs following discharge. The Department of Institutions should consider a contractual goal of re-hospitalizations in the twenty to forty per cent (20-40%) range of total admissions. The current rate for the state hospital is double that figure.

Structurally there is a good working relationship between the Pre-Release unit at the hospital and the community mental health centers. Given that three social workers on the Pre-Release unit need to be kept up to date on the statewide local service capacity and maintain local referral contacts which frequently change, the discharge process of this unit functions well.

Problems appear when persons are discharged without community treatment plans having been developed. Also the system, according

to the Board's consultants, appears to be far too reliant on requiring the patient to follow through on completing the community service connections. The transition from an inpatient setting to community setting is a critical time and the burden of treatment follow through should not rest entirely on the patient. More ownership on the part of community mental health centers' regarding assertive outreach and engagement of persons being discharged is critical. The Department of Institutions may want to consider a contractual requirement which would direct each center to assure clinic appointments and mutual treatment plan development for all persons being discharged within two to four days of discharge, and preferably prior to discharge.

Another problem area discussed during the site review is that hospital staff will frequently not approve discharge because they are waiting for a group home opening which often will mean a several month wait. The perspective that patients need structured living arrangements in order to be discharged must be corrected. The Board consultants estimate that ninety per cent (90%) of the patients released from the state hospital should be capable of independent living with case management and other appropriate community supports. The reality of what the patients should expect upon discharge and attempting to work within the parameters of local resources in a supportive manner is critical in achieving a therapeutic discharge. The state hospital and the community mental health system need to encourage mental health consumers and build their sense of self confidence in managing their illness and making

their own life decisions. The Board's consultant noted an undermining of consumer confidence in several interviews with state hospital staff and the patients. Given the current imperfect state of psychiatric care, crises and other unavoidable events will still occur, but they should not be held as the norm for mental health consumers.

There has been a slight increase in the geriatric population at the Warm Springs campus and a decline in the same population at Galen. Fiscal year 1990 data indicates an average daily census of 47.81 and in Fiscal Year 1988 the average daily population was 42.37. The average daily census for the Acute Care unit at Galen continues approximately the same: Fiscal Year 1988, 14.87 and Fiscal Year 1990, 13.94. There is however, a decrease in the Galen intermediate care population: Fiscal Year 1988, 84.79 and Fiscal Year 1990, 71.06.

Staff from the Geriatric Unit do not believe the federal Omnibus Budget Reconciliation Act legislation has had an impact on admissions to the unit, but rather residents are coming from nursing homes because of unmanageable and difficult to treat behaviors. In the last year fourteen people have been discharged from this unit: three were referred to the Center for the Aged; seven have returned to live with their families and four were referred back to community nursing homes. Discharge planning is successfully coordinated with the Pre-Release Unit, although, to minimize relocation stress, residents are not physically transferred to the Pre-Release Unit.

Recommendations:

6. Admission criteria, which sets the mission of the hospital as a provider of acute psychiatric treatment for the mentally ill, will help address the problems raised by inappropriate or questionable admissions. Admission criteria to the state hospital needs to be re-examined and revised.

Inappropriate admissions (i.e. persons who are developmentally disabled, head injured, others who do not meet the definition of having a serious mental illness) cost valuable staff time and present numerous challenges in being discharged from Montana State Hospital. Once the hospital determines its psychiatric treatment admission criteria, they must educate the various community providers, the legal and judicial communities about the active treatment services available at the state hospital.

Persons admitted to the state hospital with diagnoses of borderline intellectual functioning or mental retardation pose special challenges to the hospital staff because once admitted these patients experience great difficulty in ever getting discharged. Most often the community residential setting which the person left is filled by a new person. The consumer admitted to the state hospital is labeled a "psychiatric patient" which often precludes placement in a group home for developmentally disabled and results in extended periods of waiting at the state hospital. Moreover, the inpatient treatment available for these persons is frequently limited to chemotherapy and recreation.

Consideration should be given to authorizing admission of

these individuals with the understanding an individual's residential slot remains open for up to sixty days. This would help ensure that persons with a developmental disability receive acute treatment within an inpatient psychiatric program and yet guarantees discharge to their community setting. Such an approach would also challenge the Warm Springs staff to stabilize the patient in order to avoid extended inpatient placement. The Department of Institutions needs to establish cooperative arrangements with the Department of Social and Rehabilitation Services to address this issue.

Concerns were also expressed about transients who come to the hospital requesting admissions. While the statistics provided by the hospital are not high (4-5% of admissions), these admissions can nonetheless be disruptive and inappropriate. The state hospital should not serve as a sanctuary for the homeless. Populations, such as transients, may need to be housed overnight, but then should be sent elsewhere.

While most of the Indian Health Service admissions are appropriate, there are instances of selected tribal courts issuing commitments outside of state statutory guidelines and/or ordering inappropriate treatment. It is the responsibility of the hospital to develop psychiatric admission criteria and to admit and discharge patients consistent with the treatment programs available. The voluntary and involuntary admissions referred through Indian Health Services should be processed consistent with criteria used for all other patients.

The state hospital can and should exercise its statutory authority and responsibility to discharge persons who do not continue to meet standards for commitment. The hospital will have to become proactive in seeking to discharge inappropriate admissions, whether civil or criminal, if inappropriate admissions are ever going to be curtailed.

7. Admission criteria should be applied to all voluntary admissions until such time as there is a comprehensive screening system in place within each community mental health center region. The Board's consultants noted that the current admission process has far too many persons involved in the appropriateness of admission decisions (general medical practitioner, county attorneys, sheriff's departments, Indian Health services, private practice mental health professionals, etc.). The development of a uniform standard determining when state hospital care is necessary and is in the least restrictive setting for a clients treatment needs is of critical importance.

The Board's consultants questioned the philosophy which supports patients ability to voluntarily live for extended periods of time at the state hospital. Given the scarcity of public mental health dollars, this practice needs to be carefully evaluated. Patients who are not engaged in active treatment of mental illness, patients who are not in the least restrictive setting for their treatment needs, patients who are using the state hospital as a homeless shelter, a group home, a retreat from the criminal justice system, should be cared for elsewhere.

8. Consultants with the Board identified the need to have discharge planning begin at the time of admission. The system currently in place at the Warm Springs needs to be re-evaluated to determine how discharge planning can be coordinated for all patients. The Pre-Release unit frequently is notified only hours before a discharge thus making coordination difficult. Effective planning cannot be accomplished in this manner. Community services cannot be arranged and application for public assistance cannot be accomplished on such short notice from other units. The added stress this creates contributes to a tumultuous transition into the community and increases the likelihood of a return to the hospital.

9. Admission and discharge information is provided quarterly to the regional mental health center representatives of the Admission and Discharge Review Team.(ADRT) The Admissions and Discharge Review Team, which has been in operation since 1984, includes representation from the Community Support Programs and/or Alternative Services staff of community mental health centers, the Center for the Aged, the Department of Institutions, Montana State Hospital, the Board of Visitors, the Mental Health Association of Montana and the Alliance for the Mentally Ill. According to the Community Mental Health Standards established by the Department of Institutions, the purpose of the Admissions and Discharge Review Team is to monitor and coordinate admissions and discharges from the state hospital.

The Board recommends the hospital provide additional admission information which would identify by region, the total number of bed

days per admission per region. In turn, the hospital is encouraged to implement a procedure which calls for a case utilization review and a review of treatment recommendations (by staff from another unit) on all voluntary admissions which exceed 180 days. The case review should include why the person needs inpatient hospitalization, a summary of treatment needs, status of community referral efforts and justification of continued stay at Montana State Hospital. Attention should also be paid to persons who are admitted to or remain at the hospital as voluntary patients, but who lack the capacity to make such decisions.

CONSUMER ISSUES:

Several positive changes were made in the Patient Grievance procedure within the past year. In an effort to resolve problems or clarify procedures, the process now includes an informal meeting with the unit supervisor and the patient. Included now in the process is a Patient Grievance Committee, comprised of two hospital staff, a patient representative and an advocate. From all reports the new process is an improvement.

Information regarding patient rights and the patient grievance procedure is distributed at the time of admission. Rights posters were displayed on all units. The Nursing Home Bill of Rights was posted on all geriatric units.

In the last year an incident of staff-to-patient abuse occurred one of the long term units. The swift and immediate response of the hospital to this incident points out compliance

with the Elder Abuse laws.

A number of positive changes which directly affect the patients have been made on the Warren Building. This includes no longer locking patients out of their rooms during the day and the removal of the time-out chair from the day hall.

Exterior building signs have been placed throughout the Warm Springs campus. This feature serves new patients, family members and provides reality orientation for the elderly patients. The hospital chapel has been relocated to the multi-purpose building. Facilities are now accessible for patients, visitors and staff.

Upon their visit, consultants found patients of the geriatric units were out of bed and appropriately dressed. Commercial incontinence briefs, instituted since the last site review, are being successfully used in conjunction with a rigorous every two hour toileting program for those with bowel and bladder dysfunction. On the Long Term Care Unit, (Spratt 219) only eleven residents were needing the briefs.

Aggressive cleaning schedules are maintained on the geriatric units of the Warm Springs and Galen campuses. Common resident areas and hallways are swept and mopped daily with minimal disruption to ward activities. The hallway on Crockett III was poorly prepared for new flooring and in many places looks as though it has pockmarks. For people with visual deficits, this potentially creates the illusion of differences in floor levels and can lead to stumbles and falls. Wards were decorated in keeping with the holiday season and orientation boards were visible.

A large screen television has been installed at the Galen campus. It is used for resident Sunday movies and staff in-service training. The Recreational therapy staff report an increase in resident attendance with this new equipment.

The Crockett II nursing staff are to be commended for the care given to patient #19445. This patient underwent extensive surgery in Butte and returned to the Galen campus with a large, gaping buttock incision that is beginning to heal due to meticulous nursing attention.

Recommendations:

10. Consumer groups need to be established at the state hospital. A number of the consumers at the hospital expressed an interest in participating and learning more about their roles. With the development of the Consumer Support Project, the Board urges the this project to include the state hospital consumers. With more consumer groups being established throughout the state, a consumer group at the state hospital will bridge an exchange of information and community services among the patients.

Information for family members, friends and visitors also needs to be made available at the hospital. Information should include, but is not limited to how to contact professional staff, an overview of treatment programs, visiting hours, mental illness and medications, and the average length of stay.

11. Medication education for the consumers should take place on each of the units at the state hospital. Patient education at

a minimum must include information regarding mental illness, side-effects, avoidance of relapse, and medications.

12. As mentioned in previous reports, the hospital needs to develop a policy and procedure to clarify the status of those individuals who are unable to give their own informed consent regarding their treatment and medical care.

13. The hospital continues to have no written policy on patient's sexual interactions or conjugal visits. The Board's consultants found a variety of staff interpretations and proposed interventions. Different standards exist within the hospital and within the various units. One overall policy needs to be developed.

14. Hospital staff are encouraged to use more positive, less archaic and criminal sounding words than "ground parole", when describing the patient privilege of moving freely about the hospital grounds.

15. Many of the units have "institutional" and uncomfortable couches and chairs. In day halls and hallways, the same framed pictures for several years contribute to a non-stimulating and sterile environment. Acrylic frames that could be used to contain and rotate different pictures and/or posters would be an improvement.

16. The passive smoke problem on the units created by large number of staff and patients who smoke and the inefficient ventilation systems throughout the hospital is of concern to the Board. Given the research evidence available regarding the lethal

effects of tobacco, the hospital needs to examine the current practices.

TREATMENT APPROACHES/TREATMENT PLANS

SHORT TERM UNIT

A significant proportion of hospital resources are dedicated to treatment programs for persons diagnosed as Borderline Personality Disorder, Antisocial Personality Disorder, Narcissistic Personality Disorder, etc. The Board's consultants observed that staff have developed a specialty program for this populations currently at the hospital. Staff on this unit indicated persons with personality disorders will enter an inpatient setting primarily through other diagnosis such as major depression or suicide attempts. The staff also believe undiagnosed personality disorders frequently disrupt other hospital wards. Staff observed that treating individuals on one ward and gearing the treatment intervention to deal with their problems has been effective. The treatment approach used for persons with personality disorders on C Ward identifies the patient problem and sets treatment goals for each of the frequent defense mechanisms. Patients are involved in monitoring their own behavior and the behavior of their peers. Group therapy has been the treatment of choice, with patients serving as co-therapists. One-to-one counseling is discouraged by staff.

During the first ten months of calendar year 1990, thirty eight per cent (38%) of the total admissions to the state hospital

were diagnosed with a personality disorders. Many of these individuals also have substance abuse problems. While the treatment approach on the Personality Disordered Unit reflects the most current thinking in how to structure treatment programs, the issue which needs to be reviewed is whether this structured treatment approach should be offered on an outpatient or an inpatient basis. Most state hospital systems have not incorporated a treatment program for this population, believing that the level of support required for these disorders should be made available through outpatient services. Many persons involved in the treatment of this client population would argue that hospitalization increases dependency needs for persons with personality disorders and is therefore of questionable therapeutic value.

While the Board questions the need for a Personality Disordered Unit at the state hospital, the hospital staff who established this treatment approach for perhaps the least valued and often times the most trying segment of the treatment population should be applauded. If the energy, research and effort that went into planning and operationalizing this unit were evident across all treatment programs of the hospital, the inpatient psychiatric needs of our state would be better served. The principles used to establish this unit need to be reviewed by the hospital as they provide clues to the foundations of active treatment.

EXTENDED TREATMENT

The Board is very concerned that there has been no comparable

comprehensive treatment approach for the number of seriously ill schizophrenic patients. A systematic plan of service for persons suffering from a severe and persistent mental illness must be implemented at the state hospital. Such development must evaluate existing treatment programs and their relationship to the mission statement, consumer needs, staffing levels and projected needs of new programs which are being recommended.

There are several innovative and enthusiastic plans for the patients of the Extended Treatment Unit. While the new Unit Supervisor has made many positive changes, the Board sensed resistance from many staff as they have developed longstanding patterns of interaction with the patients on this unit. Most of the interactions observed by the Board were not therapeutic in nature.

FORENSIC TREATMENT UNIT

The Board's consultants observed a greater emphasis now being placed on treatment issues on the Forensic Unit. This is clearly a positive effort and one which must be applauded. In November, 1990 the Forensic Unit was re-organized in an effort to separate the criminal commitments and referrals from Montana State prison from the other populations currently housed on the Forensic Unit. Specifically, the units are no longer referred to as female, low, medium and high security. Rather they are now organized as court-ordered, female and high security wards. The high security unit

is now divided into separate court-ordered evaluation and a treatment wing. The court-ordered ward is being developed as a prototype for the other wards. There are plans to develop this as a more intensive treatment unit, to provide ward jobs for patients, and to shore up the three level system already operative on this ward. A waiting list for court-ordered evaluations is maintained. Hospital staff estimated a wait of one to two months. The court-ordered evaluations prepared on this unit were of good quality. Appropriate psychological assessment measures are employed and reports were coherent and well-structured. The review identified that the Medical Records Department has at least twenty five cases of incomplete records for persons who were court-ordered for evaluations. The records are incomplete and/or missing discharge plans, a psychological evaluation etc. These deficiencies need to be corrected.

Problems on the Forensic Unit as outlined by the unit supervisor include the heterogenous mix on the women's ward. They have geriatric patients, patients with severe, disabling mental illnesses, mixed with young more aggressive women. Tragically, elderly women are prayed upon and this ward has the highest level of violence by far as compared with other units at the hospital.

A second problem is for the Behavioral Unit where two organic brain syndrome patients, as well as geriatric patients, mixed with other male patients, clearly create the appearance of a warehousing situation rather than a treatment one. This area appears used for housing patients that are not wanted by other hospital units.

Developing a clear mission of the Forensic Unit is difficult because of the two distinct populations which are served: short term patients and long term patients, as well as the two distinct populations of civil and criminal commitments. According to the unit supervisor, mixing the two populations, has created problems with group therapy goals. Future unit goals expressed by the supervisor include: integrating men and women staff (particularly in terms of the women's unit); integrating men and women patients on at least one ward, operationalize the MANDT training on a more practical level and increase in-service training which would focus on more effective interactions, staff understanding of therapy and medications, and staff burnout.

Rehabilitation/activity therapy and chemotherapy have been the major forms of treatment on the Forensic Unit. The addition, however, of a new psychologist to the Forensic Unit is a significant development. As of the site review, groups (e.g. social skills, a general therapy group and a women group) are being developed and at least six patients were being seen in individual therapy. The Board encourages an ongoing evaluation to identify other patients who would benefit from individual therapy. Development of treatment and activities is challenging considering the markedly heterogenous patient population ranging from schizophrenics, organic brain syndromes to character disorders.

LONG TERM CARE UNIT (Spratt 219)

The only unit licensed by the Department of Health on the Warm

Springs campus is the Long Term Care Unit. Of significance to the Board reviewers was the fact that the recent licensing survey for the Long Term Care Unit found only a single deficiency and this was reportedly related to "non-individualization" of clothing for some of the residents. The staff of Long Term Care Unit are to be commended for their consistently integrated physical/medical and psychiatric care.

Since the last site review, the Recreational Therapists and Social Worker positions have been filled on the Long Term Care Unit. A certification training program has been provided to all the nursing assistants in compliance with the OBRA requirements. Recreational Therapy staff were also required to complete the Nursing Assistant Certification program. This certainly speaks to the commitment of increasing staff knowledge at many levels. In addition to the physician's daily rounds, a psychiatrist now makes daily rounds on the unit. Medications can be reviewed and adjusted on a more timely basis, plus access to the doctor has been valuable for the staff.

Daytime, evening and weekend activities are available for patients of the Long Term Care Unit. Options include resource materials for sensory stimulation and remotivation therapy, current events, exercise, reading cart, outings etc. One-to-one time is provided for those residents who are unable to attend a scheduled event.

Staff are to be commended for the development of the Trivia Board. For every day of the month, some bit of information related

to an event or person was printed in oversized, readable letters. This information was hung in the hallway for residents to read. It is apparently meeting with considerable success and is a useful tool for memory stimulation and reminiscing. The Board's consultant suggests laminating these sheets so they remain usable and attractive over time.

The nursing staff of the Long Term Care Unit are in the process of using a newly created monthly flow chart for documenting ambulation, transfer, toileting, eating/feeding, appetite, orientation, sleep patterns, activities, weight, restraint usage, behavioral/mental status etc. This system will allow the staff to have a broader picture of residents holistic functioning on a one-page document. As the "Behavior/Mental Status" section documents only maladaptive behaviors, the Board's consultant suggests staff add "positive" behaviors or those observations related to psychosocial well-being, unless by inference no charting means only adaptive behaviors are occurring.

GALEN CAMPUS

Staff from the Galen campus raised many concerns regarding the potential closure of the hospital. Since the Board's site review however, the 1991 Legislature has determined that the Galen campus will remain open. In addition the legislature has ordered a study of the various programs affected by the proposed closure. The Board of Visitors endorses a study to include broad-based representation of consumers, health care professionals and

legislators. Treatment considerations and alternatives must include proper assessment, consideration of the least restrictive treatment environment, normalization and active treatment needs.

Full-time physician coverage continues to be available at Galen. The staff report a psychiatrist remains available for consultation. Certification training, per the OBRA requirements, has been provided to the Galen nursing assistants.

Staff of the Galen campus are very conscientious about the physical needs and appropriate nursing care. Treatment approaches identified a number of health and medical approaches. The Galen staff was especially proud of an outdoor barbecue held on the campus. Arrangements were made for all the patients to attend and participate to the extent possible.

A past report of the Board documented concern regarding the use of a "hybrid" restraint/seclusion policy and supportive restraint policy used on the Galen campus. A random review of files indicates there has been a conscientious and deliberate effort made to remain in compliance with Hospital policy. The Board's consultant noted the physician orders still do not consistently contain the type of restraint used, the location of application nor a notation about monitoring restraint or seclusion and release from them.

Recommendations:

17. A programmatic direction and treatment orientation for the state inpatient hospital must be determined. Once it is

determined what population will be served the hospital needs to identify what programs are needed in order to serve the population.

18. The treatment plan format and process needs to be revamped at the state hospital. One of the Board's consultants provided background information and sample forms in an effort to assist the hospital staff in considering a new format.

19. Treatment plans, for the most part, were very generalized in nature. It was very difficult for the consultants to tell who was carrying them out. On both the Extended Treatment Unit and the Forensic Units the charts did not clearly indicate that treatment plans were in fact being implemented. The chart section entitled, "Progress notes" is a misnomer, as the entries made are predominately behavioral observations rather than actual charting of a patient's progress along his treatment plan.

On the other hand, the geriatric units continue to formulate treatment plans with treatment based on identifiable and targeted maladaptive behaviors. See files 51869, 51791, 20071, 20063, and 13656. For those residents whose medical needs are priority, treatment plans were also formulated appropriately. See files 15626, 16164, and 19445. Quarterly reviews were documented by all members of the treatment team. The Board's consultant observed that the reviews addressed each of the identified treatment needs and what had or had not been achieved. File 20063 documents how a monthly nursing care review used records and charting to alter a treatment plan. Staff from other units should be encouraged to review treatment plans from these units.

The accepted standard practice for inpatient psychiatric programs is that the treatment plan is part of the treatment record. The psychiatrist on the review team indicated this was the only hospital he has surveyed that has the treatment plan kept separate from the record.

20. The practice of making entries on the treatment plan in pencil and then erasing them must be discontinued. Several treatment plans, activity flow sheets, recreational therapy forms and social service flow sheets did not include the year.

21. Treatment approaches addressing drug and alcohol problems must be incorporated into the overall Warm Springs program. Certified drug and alcohol counselors must work in conjunction with treatment staff and incorporate education, treatment approaches and support systems. The Board also supports the development of Alcoholics Anonymous and Narcotics Anonymous support groups for the patients.

22. Staff on the Extended Treatment Unit do not appear to be interacting enough with patients in a therapeutic manner. Observations rarely included interactions that would foster independence or personal growth. Moreover, there is lack of treatment opportunities provided in the program. Patients are presently provided with a variety of activity experiences which include work, school, auto repair, carpentry, exercise, etc. Unfortunately, many of the patients do not always avail themselves of the opportunities provided. A motivational or incentive system should be provided to increase patient participation in the

program. The Board's consultants stated the level system needs to be made more explicit. Moving within the current level system is often times subjectively determined. If the system were more objective in nature, there is some likelihood that patients would be responsive to it.

Treatment issues are further complicated by the high number of inappropriate admissions to this unit. The Board recognizes and encourages the development of the group therapy experiences planned for the unit. The treatment needs of persons with a severe and persistent mental illness must be evaluated and a comprehensive inpatient program must be developed.

Staffing for this unit needs to be re-evaluated. At the time of the review there was one psychology intern for one ward of a unit which serves the most disabled population of the hospital. The assignment of, at minimum, one full-time psychologist to the Extended Treatment Unit would benefit this unit. The social work staff spend a lot of time looking for placements outside the hospital, when this task should be coordinated with the Pre-Release Unit. With the limited number of professional staff on this unit, their time must be directed to provide treatment opportunities for the entire patient population.

23. File 25002 indicates an identified problem ("verbally, abusive and threatening"), a goal to reduce the behavior to one time daily, and several acceptable approaches. While the approaches are appropriate, ("firmly let him know his behavior will not be tolerated") the Board's consultants suggests eliminating the

punitive phrase "....and it will not get him anywhere".

24. The Board's consultants suggests including the therapeutic effectiveness of work on the treatment plans. Work certainly contributes to a sense of autonomy, self-esteem, relationship building, independence and structure and could be worked into the treatment plan where problems exist in these areas. The Board also notes that there is a statutory requirement for weekly documentation of work activities and the effect of that activity upon the patient's progress along the treatment plan.

25. Resident 15626 was at eight-eight per cent (88%) of ideal body weight and was being monitored by the nursing and dietary staff. The Board's consultant noted that for someone whose appetite is a problem the staff should make more than a check mark beside "appetite; fluids encouraged." If, as documented 11-22-90, "appetite varies" then estimates of percentages of food and liquids consumed would be more accurate than subjective judgments of intake that is "good, fair, or poor".

25. The orientation board on Terrill I identified the day as Tuesday, when it was Friday. The staff used a ReMarkable Board as a monthly calendar of activities and it was smudged and difficult to read. The Recreation/Activity staff may want to explore other alternatives to make the calendar more readable.

26. The Board and its consultants were extremely concerned about the women's ward of the Forensic Unit. There is a great mix of clients, staff-patient interaction problems obviously exist, and the patient population is extremely difficult to handle.(i.e.,

violent, noisy, argumentative, etc.) Plans to provide for coed living units, must be implemented as soon as possible.

27. Criteria for the types of placement on the forensic unit needs to defined. At the time of the review, three elderly and/or physically disabled persons in wheelchairs were on the forensic unit. The continued placements of these individuals on the most restrictive unit of the hospital needs to be re-evaluated. Consultants to the Board believe with increased training of staff and/or an increase in staffing on a more appropriate unit, these individuals could and should be served elsewhere in the hospital.

28. With the number of civil patients on the forensic unit, the Board's consultants, stated that the draft policy needs to be further developed and strengthened. The Board's consultants commented that the policy needs to include documentation in the permanent record of alternative interventions and treatment approaches on other units that were used and failed. The policy also needs to include regular administrative reviews by the director of treatment services or the superintendent of the hospital and/or the Department of Institutions.

One consultant, based on his experience, stated that very few civil patients should or need to be on forensic units, and confining one sixth of the hospital's civil patients on the Forensic Unit is inappropriate. The hospital needs to critically examine this issue in light of the mandate to confine patients in the least restrictive setting appropriate to their treatment needs.

29. There continues to be problems regarding the transfer of

patients to the Forensic Unit and the documentation necessary to justify such a placement. In turn, patients who are frequently placed on the unit have difficulty returning to less restrictive settings within the hospital.

Placement on the unit is further complicated because some of the patients on the Forensic Unit indicated a preference to stay on the unit. Their reasons included, private rooms, nicer space and building, better recreational equipment and not being forced to do anything. Patients should not be able to dictate the restrictiveness of their environment, except for short duration crisis situations. Treatment staff need to take a more proactive role in transferring patients to less restrictive treatment settings.

30. The primary management problem with patient 38156 involves excessive water intake and the treatment of choice has been to lock him in seclusion so he would not be able to drink from non-secured water supplies. The treatment team needs to consider some other alternatives in dealing with his excessive water intake, short of locked seclusion and a whole wing designated for this purpose. Increased involvement in activities off the ward and increased personal attention and interaction by staff should be considered.

31. Patient #37564 was being considered for placement on the Medium Security Unit, but he noted that he would prefer being on High Security. Charts revealed that he "never attends activities", and treatment apparently involves watching this patient eat and

sleep. The patient stated he couldn't handle the Medium Unit and wants to be sent to High Security, although his reasons for this request were not explained. The Board's consultants do not agree that a patient's request for a higher security unit where one can eat and sleep more is therapeutic justification for a level change.

32. Patient #36135 had been placed on a mild tranquilizer, one stomach medication with a tranquilizer and one tranquilizing anti-depressant, although he had been diagnosed as a long time drug abuser and had been treated at the Lighthouse Drug Treatment Program. The hospital must document there rational for providing these medications, given this history.

33. At the time of the review, Patient #38176 on the Forensic Unit was receiving eight different medications. These included, Zantac, Serentil, Prolixin, Lithium and Sinequan. In addition, this patient carries multiple diagnoses, including: paranoid schizophrenia, anti-social personality, borderline personality disorder and suicidal gestures along with a diagnoses of drug and alcohol abuse. This smorgasbord of diagnoses should be refined so that a more focused treatment could be offered, particularly in terms of the medication intervention. See the Medication Appendix.

SECLUSION/RESTRAINT

As mentioned previously, the use of the MANDT training will aid staff in dealing with aggressive and non-aggressive behaviors. Staff on some of the units expressed the need to have their skills updated. The hospital reports that training opportunities at the

hospital are being developed at to address this need.

Only ten residents on the Long Term Care Unit require supportive restraint. The consultant's review of the clinical records document staff are conscientiously following hospital policy and requirements. (H.O.P.P. 13-03RS. 060183)

The Montana State Hospital policy for restraint and seclusion has been revised as of February 1990. (H.O.P.P. 13-03R.070073) Changes included in the policy provide for: the physician's order to include some indication for the duration of an episode of restraint and seclusion; requiring licensed staff, though not only certified professional persons, to review a person's placement in seclusion and restraint at least every three hours; and changes in the criteria for determining when restraint and seclusion incidents must be reported to the review committee.

Recommendations:

34. Consultants to the Board urge the state hospital to review the standards established by the Joint Commission on the Accreditation of Health Care Organizations. Policies and procedures pertaining to seclusion and restraint must be revised and upgraded to meet the current accepted inpatient practices.

According to the Board's consultant, the hospital is out of compliance with national standards such as the Joint Commission on the Accreditation of Health Care Organization standards in keeping civil patients in cells on the Forensic Unit. Whenever a patient is kept in a room alone with the door locked, this is considered to be seclusion. All aspects of seclusion must be carried out

including evaluations of the patient, doctors orders for seclusion, fifteen minute checks, etc.

The Board's consultant further noted that other states forensic facilities retain forensic evaluation patients in cells only until their individual level of dangerousness is assessed. The hospital needs to re-evaluate their current policy of keeping forensic patients in a cell for the majority of the day.

35. The Board's consultants observed that the restraint/seclusion policy is not being implemented on the women's ward of the Forensic Unit as outlined in the state hospital procedure manual. For example, patients in restraint were not being regularly checked every fifteen minutes. With this policy in particular, staff must make every effort to follow it.

36. The Board's consultants observed inconsistencies in using the required language on orders of seclusion and restraint. File #19445 had an order for "protective restraint, if necessary". This order does not specify the words "supportive restraint" per policy requirement; does not specify the type of restraint; the reasons for its use, the location of application or the duration. "S/R (side rails) check every hour to prevent falls and injury" was indicated on one order, but again this does not fall within the definition of supportive restraint. If the initial intent was to require side rails and no other type of restraint, then the use of "protective" needs clarification. "Humane restraint" is being used synonymously with "Supportive Restraint", but it is a brand name for a particular style of cloth waist restraint used in bed.

37. A policy and procedure needs to be developed whereby a central analysis of the use of seclusion and restraint is reviewed and evaluated at regular intervals: daily, weekly, monthly and yearly by a competent professional. The implementation of such a policy will help determine problems in staffing, problems with personnel, any need for treatment plan review or to determine trends in the use of seclusion and restraint.

38. A critique of restraint and seclusion episodes after the event by all staff involved should become a standardized procedure at the hospital. Such reviews of restraint and seclusion incidents are currently made only on a sporadic basis.

39. The fifteen minute observation notes of patients in seclusion and restraint sometimes indicated calm, quiet or otherwise appropriate behavior, yet the seclusion and restraint was not terminated. Charting should indicate the behaviors that justify continued use of restraint and seclusion.

40. The revised restraint and seclusion policy provides for review of all persons in restraint and seclusion by a certified professional or licensed staff at least every three hours. This review is not always charted, which indicates the review has not been performed. Ongoing training for certified professionals and other licensed staff on restraint and seclusion, particularly initial justification and continuing justification, should be provided on a regular basis.

41. Ongoing training of all treatment staff on restraint and seclusion and alternative interventions should be required at the

hospital. The use of restraint and seclusion is a difficult and tense experience for both patients and staff. Continual training is one way to alleviate the tension associated with the use of restraint and seclusion.

STAFF/STAFFING ISSUES

Although the hospital is authorized six psychiatrist positions only two of those positions are filled with full-time psychiatrists. The hospital continues to contract with Comp-Health for two psychiatrists. Recruitment for the vacant positions continues to be very challenging. The other significant staff shortage for the hospital is that of registered nurses. At the time of the site review, there were six and one half vacancies.

Two hundred direct care staff were trained in the MANDT intervention procedures. This two day course not only trains staff in five levels of physical intervention, but teaches levels of non-physical intervention that can be used to de-escalate potentially serious situations.

More computers are needed throughout the entire Warm Springs campus. The Medical Records department (Warm Springs and Galen campuses) currently operates without a computer, while all other Medical Records Departments within the Department of Institutions have computers. Considering the high rate of admissions, significant time could be saved and redirected if patient information within this department were computerized. Campus-wide, all treatment units and departments would benefit from the

availability of computers.

Recommendations:

42. The shortage of psychiatric staff allows little time for aspects of treatment, treatment planning and development, other than chemotherapy. The current psychiatrists and the Comp-Health psychiatrists on contract at the time of the review were observed to be very dedicated, caring and competent individuals, despite the fact that staffing of psychiatrists is totally inadequate.

43. A significant number of patients (38-50%) are diagnosed as having a documented drug and/or alcohol problem in conjunction with their mental illness. In past reports the Board reports have documented the need for alcohol and drug counselors to be housed at the Warm Springs campus. This unmet need continues and must be corrected as soon as possible.

44. The Board urges an evaluate and study of the nursing services at the Warm Springs and Galen campuses. The Board's consultants observed a great deal of disparity among the nursing staff in their duties, capabilities and responsibilities on the various units. (For example, on one unit, the registered nurse stated she was not a member of the treatment team. On yet another unit, the registered nurse was responsible for the staffing assignments for the hospital. Medication delivery was the sole responsibility identified by another nurse. One of the supervising nurses interviewed appeared to be only minimally functioning as a ward nurse.)

Such an analysis of the nursing services should also address

the function of supervisors in non-professional duties. When there is a lack of professional staff, it is a poor use of resources to have supervisory staff performing functions an administrative staff member can do.

Among the seven treatment units there are only 28.5 authorized nursing positions and 6.5 vacancies. The Board's consultants stated this represents not only a significant nursing shortage in terms of the vacancies, but an under representation of nursing personnel in the hospital staffing profile.

45. The Board's consultants felt the professional staffing for the Extended Treatment Unit was grossly inadequate. There is a need for psychologists and substance abuse counselors to address the many dual diagnosed patients on the unit as well as develop and maintain active treatment programs responsive to the needs of that particular patient population.

46. The review team encourages the hospital to evaluate the use of a nurse practitioner or physician's assistant to conduct the admission physical examinations performed on the intake unit. The Board's psychiatric consultant commented this change would allow the psychiatrist to do what they are hired and trained to do best. Most inpatient psychiatric facilities use family practitioners, internists, a nurse practitioner or physician's assistants to do the admission physical examination.

47. Although a variety of staff training is provided on grounds, there is not adequate money for this program. The staff responsible for this program are extremely creative and frugal in

arranging the staff education and training that does exist. Serious consideration should be given to adequately funding staff development such that a comprehensive and mandatory training program can be developed and maintained at the hospital.

48. The Board and its consultants urge the administration to include all levels of staff in the development of the mission statement and priorities of treatment programs. Addressing these issues are important as some of the self starters on the staff, commendably, are beginning to develop programs or in some cases use time and resources for some patient groups whom the hospital may determine should not be served in an inpatient setting. We believe there could be a serious morale problem for staff if time and effort is invested in developing programs for brain injured, sex offenders, etc. and then the mission is changed to care for these persons in a different setting.

49. Additional rehabilitation staff are needed in order to provide evening and weekend activities for the patients.

MEDICAL/MEDICATION

PHARMACY

Improvements continue to be made in the pharmacy. The additional space will be useful given the number of people working in such a very small space. Computerized medication administration records (MAR), scheduled to be implemented in all treatment units, will save considerable time for nursing staff and should assure accuracy from month to month.

Pharmacist review was documented on the Long Term Care Unit and at the Galen campus. This review is helpful in fine tuning medications and should be expanded across all units of the hospital. In consideration of the psychiatrist shortage, the hospital may want to consider adding a clinical pharmacist specializing in psychopharmacotherapy. Such a person could help evaluate clinical trials with psychotropic agents, identify adverse effects due to medications, record medication history and extrapyramidal adverse effect information. Just as psychologists help in evaluating the clinical status of patients, the clinical pharmacists could be a valuable addition in helping conduct systemic evaluations of pharmacotherapeutic trials.

The Board and its consultants were very pleased to see the process established to evaluate the need for the new antipsychotic agent, Clozaril. Once started on the drug, proper monitoring was undertaken and it regular monitoring and evaluation of drug benefit was examined.

MEDICATION

There has been significant progress made in the recording of allergy information, although some improvements are still possible. The Board's consultants recommended that an "allergy tape" appear on the outside of all charts, not just those of patients with allergies. This provides a place where all allergy information can be routinely recorded. In some of the reviewed cases, the allergy information within the chart (i.e. on the MAR and physician orders)

did no match that on the allergy tape. A history of drug abuse is not consistently documented on the same form. The file review found reference to drug abuse within the mental status examination, social history, medication history form, and the physical examination form. Efforts must be taken to obtain and document this information in one place. The addition of chemical dependency counselors would aid in obtaining this history.

The dosages of all medications reviewed were within acceptable limits. Serum concentrations to verify adequate dosage were measured appropriately with one exception (see case 40-22337). The daily dosage of psychotropic agents was split in cases 4-38136, 24634, 3-20063, 2-51103. These agents, according to the Board's consultants do not need to be given more than once daily. In fact, it is usually preferred to administer them once daily to limit the required nursing time, simplify the administration schedule and permit side effects to be predominant at night when they are less noticeable by the patient. Lithium is the exception to this rule because of the problems with gastrointestinal side effects with large dosages. In once case lithium syrup was administered once daily (4-15091), despite gastrointestinal complaints.

There were two "as needed" orders for which there is a concern. In case 2-36733, a medication was ordered without an interval between dosages stated. This can lead to overdosage. In the second case, 4-15091, a very slow onset drug was prescribed in a situation where a rapid onset is desired.

The review of prescribed medications as represented by

frequency of psychiatric notations in the chart has improved. However, the content of these notes is often less than informative, especially on the Forensic units and on the Galen campus. These notes should specifically address the efficacy and side effects of current medication and also outline the therapeutic plan. This will allow other staff to help assess the success of drug therapy and integrate it into the treatment plan.

Recommendations:

50. According to the Board's consultant, the hospital should have a tardive dyskinesia policy. It is standard that inpatient psychiatric patients be examined with an AIMS examination (Abnormal Involuntary Movement Scale) or like evaluation at the time of admission and at regular intervals throughout their treatment program. Nursing staff can be trained to do these evaluations with consultant from the physicians. The Board's consultant emphasized that this is a high risk medical legal area which should be addressed by the state hospital.

51. As mentioned in the consumer section of this report, medication education and training should be implemented on each of the units. The Board and its consultant commend the units which are incorporating self-medication into their programs. This practice, coupled with education, empowers consumers to be responsible for their own medical care and management of their illness.

52. Since past psychotropic medication usage is important in the current prescriptive decision, the medical history form should be expanded to include a history of all psychotropic medication

usage. This would provide a valuable tool for the psychiatrist, (especially the contract psychiatrists) when faced with a clinical situation requiring a change in drug therapy. A form is attached in the Medication Appendix which demonstrates how easily this information can be recorded.

The ward chart includes a medical history form, however, in several of the charts reviewed, the form was not present or the question regarding medication was not answered. Given that readmissions to the hospital exceed fifty per cent, the hospital would benefit from collecting this data.

53. As noted by the Board's consultants, the recording of extrapyramidal symptoms is very important. It also relates to justification for use of anticholinergic agents, a therapy which generally is not documented as needed. A form for examination of extrapyramidal symptoms can be found in the Medication Appendix. The forms presents a simplistic and easy approach to record such information and could conceivably become part of the admission physical.

The record review indicated a number of anticholinergic agents are prescribed concurrently with antipsychotic agents to prevent or treat side effects. It is not necessary to continue these agents forever in the absence of continuing side effects. Usually after three months without side effects the anticholinergic dosage may be tapered and the drug discontinued without a return of side effects. The Medication Appendix identifies several cases that the anticholinergic was continued longer than necessary.

54. The Board is very concerned regarding the legal status of the geriatric patients. Informed consent should be documented. It is imperative to know who has legal authority when it comes to making legal and ethical decisions regarding health care and possibly relocation. We could find not documentation of "advanced directives", those instructions related to CPR, prolongation of life measures, organ donations or autopsy. This legal status also needs to be clarified hospital-wide.

In the case of patient 52444, a mass was identified on a chest x-ray in March, 1990. Two hospital physicians have determined that surgery is not appropriate and have elected not to treat this lesion. The ward record makes no reference to informing the patient of this condition and the decisions made. While the Board's consultants agreed with the physicians decision, the patient should be informed of his condition and have a say in his treatment. The record further indicates the patient is able to sign over his monthly check to the hospital for payment of his care and maintenance. The hospital needs to be consistent in their dealings with the patient, be it participating in treatment decisions or payment of their care.

55. Patient 42187 has been diagnosed with Tardive Dyskinesia, but continues to be placed on a phenothiazine type medication. A gradual approach for discontinuing the drug may well be indicated, but an immediate withdrawal of the antipsychotics might well aggravate the Tardive Dyskinesia symptoms. The Board's consultants suggest that some type of formalized treatment intervention should

be noted in the chart which would be consistent with acknowledging this dyskinesia as well as addressing his psychiatric symptoms.

56. Documentation of reasons for prescribing medication and for changing types and dosages of medications is inconsistent. The review indicated this documentation ranged from excellent on some units to completely absent on others. Explanatory medication notes by psychiatrists are sound medical practice, and they are especially important given the dependence of the hospital upon the Comp-Health psychiatrists.

57. Medications continue to be prescribed for adminstration several times a day when once a day would be sufficient. It is important and prudent to make medication administration as simple for the patient as possible. For example, a single medication adminstration at night makes it simpler for patients to remember to take their medications; may help to alleviate patient resistance to taking medications by having minor, but annoying side effects masked by sleep; and in most cases provides the same desired effects as multiple administrations of medications.

SUMMARY

As stated within the body of this report, the Board of Visitors believes the state hospital will continue to play a critical role as a part of Montana's mental health system. The size and future direction of the state hospital will depend upon a concise mission statement and its implementation. A state run inpatient program must focus on the psychiatric stabilization of seriously mentally ill patients. The state hospital cannot continue to try to serve all the needs of all the people in need of services. Such a monumental task prevents scarce staff and monetary resources from being used to effectively provide high quality care and services for those persons who suffer from a serious mental illness.

Once the mission is determined, the administration and staff are in a better position to determine what treatment models are necessary at the hospital. Further, the hospital administration will need to provide philosophical guidance and programmatic direction regarding the adoption and implementation of the hospital's mission. Goals for each treatment and service unit need to be re-examined and redefined. Without such planning and implementation, the hospital units will continue to function as separate entities, independent and distanced from one another.

A stronger sense of an integrated mental health system needs to be fostered and supported throughout the state. A clearer sense of the respective roles of an inpatient program and community based programs will be required on the part of all in order to give this

state and its mental health consumers the quality of mental health services they deserve.

APPENDIX A

ADMISSIONS STATISTICS-MONTANA STATE HOSPITAL

January 1, 1990 - October 31, 1990

REGIONAL ASSESSMENT OF ADMISSIONS TO MONTANA STATE HOSPITAL

(based on admissions as of March, 1991)

ADMISSION STATISTICS (INTAKE UNIT) JANUARY 1, 1990 - OCTOBER 31, 1990

Number	512
Median Age	41 years
Days on Ward Until Clinic	4.79
Total Days on Ward	7.45

First Admission	211 - 41%
Recommitments	301 - 58%
Transients	22
Time Since Last Discharge	1 year, 10 months, 6 days
Male	322
Female	190
Voluntary Admissions	209
Involuntary Admissions	233
*Indian Health Services Involuntaries	17
*Emergency Detention (Committed)	33
*Emergency Detention (Released)	17
*Emergency Detention (Signed Voluntary)	5
Petitioned For Release	32 - 6%

TRANSFERS

ITU	277 - 54%
ETU	111 - 21.6%
219	18 - 3.5%
Pre-Release	61 - 11.9%
Direct Discharge	40 8%
AT&R	8 - 1.5%
Lighthouse	0
Forensic	1 1%

DIAGNOSES

Drugs and Alcohol	202 - 39%
Psychosis	193 - 38%
Personality Disorder	185 - 36%
Affective Disorder	132 - 26%
OBS	40 - 8%
MR	11 - 2%
Borderline Intellectual Functioning	8 - 1.5%
Adjustment Disorder	23 - 4.4%
*Other	18 - 3.5%
V Code	6 - 1.1%
Eating Disorder	5 - 1%
Pedophilia	2 - .3%
Post Traumatic Stress Syndrome	2 - .3%
Explosive Disorder	3 - .4%
ADMISSIONS DURING WORKING HOURS	64.1%
*Appropriate Admissions (To Include All (IN) Voluntaries)	94.8%

James Kern Dick
Psychologist
Intake Unit

ADMISSION STATISTICS (INTAKE UNIT) JANUARY 1, 1989 - DECEMBER 30, 1989

Number	618	
Median Age	36.7 years	
Days on ward until clinic	4.1 days	
Total days on ward	6.92 days	
First Admissions	235	- 38%
Recommitments	370	- 61%
Transients	33	
Time since last discharge	1 year, 5 months, 24 days	
Male	375	- 61%
Female	241	- 39%
Voluntary Admissions	356	- 58%
Involuntary Admissions	234	- 38%
Indian Health Services (Involuntary)	4	
Emergency Detention (Committed)	11	
Emergency Detention (Released)	10	
Emergency Detention (Signed Voluntary)	4	
Petitioned for Release	54	9%

TRANSFERS

ITU	344	- 56%
ETU	139	- 22%
Pre-Release	75	- 12%
Direct Discharge	21	- 3%
Long Term Treatment #219	23	4%
AT&R	1	
Lighthouse	0	
Forensic	4	
Pintlar	3	

DIAGNOSES

Drugs/Alcohol	296	- 48%
Psychosis	228	- 37%
Personality Disorder	232	- 38%
Affective	172	- 28%
OBS	41	- 7%
Transsexual	1	
Adjustment Disorder	20	- 3%
Eating Disorder	10	- 1.5%
Borderline Intellectual Functioning	11	- 1.5%
Uncomplicated Bereavement	1	
Marital Problems	7	- 1%
Mental Retardation	16	- 2%
Pedophilia	2	

Admissions during working hours	63%
Appropriate Admissions (To include all involuntaries)	80%

James Kern Dick
Psychologist
Intake Unit

COUNTY	REGION I	REGION II	REGION III	REGION IV	REGION V	
Anaconda/Deer Lodge				10,278		10,278
Beaverhead				8,424		8,424
Big Horn			11,337			11,337
Blaine		6,728				6,728
Broadwater				3,318		3,318
Carbon			8,080			8,080
Carter	1,503					1,503
Cascade		77,691				77,691
Chouteau		5,452				5,452
Custer	11,697					11,697
Daniels	2,266					2,266
Dawson	9,505					9,505
Fallon	3,103					3,103
Fergus			12,083			12,083
Flathead					59,218	59,218
Gallatin				50,463		50,463
Garfield	1,589					1,589
Glacier		12,121				12,121
Golden Valley			912			912
Granite				2,548		2,548
Hill		17,654				17,654
Jefferson				7,939		7,939
Judith Basin			2,282			2,282
Lake County					21,041	21,041
Lewis & Clark				47,495		47,495
Liberty		2,295				2,295
Lincoln					17,481	17,481
McCone	2,276					2,276
Madison				5,989		5,989
Meagher				1,819		1,819
Mineral					3,315	3,315
Missoula					78,687	78,687
Musselshell			4,106			4,106
Park				14,562		14,562
Petroleum			519			519
Phillips	5,163					5,163
Pondera		6,433				6,433
Powder River	2,090					2,090
Powell				6,620		6,620
Prairie	1,383					1,383
Ravalli					25,010	25,010
Richland	10,716					10,716
Roosevelt	10,999					10,999
Rosebud	10,505					10,505
Sanders					8,669	8,669
Sheridan	4,732					4,732
Silver Bow				33,941		33,941
Stillwater			6,536			6,536
Sweet Grass			3,154			3,154
Teton		6,271				6,271
Toole		5,046				5,046
Treasure	874					874
Valley	8,239					8,239
Wheatland			2,246			2,246
Wibaux	1,191					1,191
Yellowstone			113,419			113,419
TOTAL POPULATION	87,831	139,691	164,674	193,396	213,421	799,013
% OF TOTAL POPULATION	10.99%	17.48%	20.61%	24.20%	26.71%	1
MSH CLIENT CENSUS 3/4/91	21	24	54	132	56	287
% OF TOTAL CLIENT CENSUS AT MS	7.32%	8.36%	18.82%	45.99%	19.51%	100.00%
CENSUS IF = TO REGION II RATE	15	24	28	33	37	137
REDUCTION BY REGION TO REGION II RATE	6	0	26	99	19	150

APPENDIX B

MEDICATION HISTORY

MEDICATION REVIEW

Medication History: What Is Important

1. Diagnosis

2. Neuroleptic response patterns

0	=	non-response
1A	=	partial (cooperation)
1B	=	partial (socialization)
2	=	remission or very substantial improvement

   — time course
   — window effects
   — tolerance
   — insight

3. Specific responses

   — typical versus atypical neuroleptics (mesoridazine, loxapine, clozapine)
   — window effects
   — milieu/psychosocial therapies/stress
   — noteworthy side effects including allergies

Procedures for Recording the Medication History

1. Evaluate each "medication treatment episode"
2. Usually record two "definitive" trials of each medication regimen
3. Add ons: record the result after the addition, if no change rate "0"
4. Medication withdrawals
5. ECT

Medication History

Patient Name _____ Page _____ Date _____ Hospital # _____ Ward _____

Medication (or combinations)	Dose range, blood levels	Date begun (month & year)	Trial duration	Response 0/1/2	Chart Diagnosis	Comments (e.g., side effects, response details)

Globally, this patient is a neuroleptic (NL) Non-responder (0)_____ Suboptimal responder (1)_____ Responder (2)_____

Differential response of atypical NLs versus Tytical NLs: Better response to typical_____ Better response to atypical_____
Similar response to _____ Never (fully) tried on atypical_____

Non-neuroleptic drug responses _____
(& milieu/psychosocial therapy responses)

Diagnosis _____ Allergies (describe) _____

Neuroleptic Threshold Examination*

Patient Name _____ Hospital Number _____

Date _____ Examiner _____

Directions

Watch the patient rise from a lying or sitting position, walk a short distance, turn, and return. Note the patient's spontaneous gestures and facial expressions during a brief conversation.

Flex and extend the patient's arm at the elbow and wrist, and rotate the wrist while the patient passively cooperates and is as relaxed as possible. Note the presence of cogwheeling or increased muscle tone. Then ask the patient to do skywriting or rapid-alternating movements with the other arm while the examiner repeats rotation of the wrist. Check both arms in this manner and record the maximum findings from either side below.

In borderline cases, cogwheeling may be hard to detect. Examine carefully or for extra time if none is appreciated, before rating as "not present."

Rating:

A. Ratchety, cogwheel rigidity. Definitely present if 3 or more "cogs" in a row are appreciated	0 Not present _____ 1 Minimal (i,=.e., only present when elicited) 2 Mild (present without elicitation) 3 Moderate or greater (without elicitation)
B. Increased muscle tone without cogwheel rigidity, or 2 "cogs" or less.	0 Not present _____ 1 Minimal (i,=.e., only present when elicited) 2 Mild (present without elicitation) 3 Moderate or greater (without elicitation)
C. Behavioral akinesia (including stiffness of gait or posture or decrease in spontaneous gestures and facial expression)	0 Not present _____ 1 Minimal 2 Mild 3 Moderate or greater

Patient is judged within the Neuroleptic Threshold if either:

A is rated 1 or greater and C is rated 0, 1, or greater

or

B is rated 1 or greater and C is rated 1 or greater

Is this patient within the Neuroleptic Threshold now? Yes _____ No _____

*McEvoy (Oaser modification) 5/2/90

MEDICATION CHECKLIST

UMBER:	3-31993	DIAGNOSIS:	Schizoaffective disorder
DMISSION:	8-17-90		Borderline personality disorder
ITE:	Warren 43		Alcoholism
BIRTHDATE:	3-12-52		Transsexualism
			Acne vulgaris
		MEDICATIONS:	fluoxetine (Prozac)
			buspirone (Buspar)
			thioridazine (Mellaril)
			multivitamin
			thiamine
			tetracycline
			Afrin nasal spray

ISTORY:

1. Medication: Not specifically documented; medications prior to admission and on discha from prior MSH admission are documented.

2. Allergy/Adverse Drug Reaction: Documentation of penicillin allergy on MAR and chart. documentation of prior adverse drug reactions.

3. Drug Abuse: Documented abuse of both alcohol and drugs.

URRENT MEDICATIONS

1. Indications: Fluoxetine is an antidepressant and thioridazine is an antipsychotic age oth are being used for symptoms associated with the schizoaffective disorder. Buspirone is gent used for anxiety, presumably a symptom of the schizoaffective disorder in the patient. hile the specific purpose of the inclusion of buspirone in the patient's regimen is not cle t has been a part of the regimen since at least the last MSH admission. The multivitamin i eing used as a nutritional supplement for presumed deficiencies associated with alcoholism, nd thiamine specifically addresses a common alcohol-associated vitamin deficiency. etracycline is an antibiotic which is effective when used as prophylaxis to decrease or revent exacerbations of acne. The Afrin nasal spray is a decongestant nasal spray; notes ndicate it is being used for nasal congestion related to thioridazine therapy.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: Nasal congestion is attributed to therapy with thioridazine (?check this). Patient has complained of drowsiness which he attributes to thioridazin There are notes present documenting the absence of extrapyramidal adverse effects from the antipsychotic agent.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: There is a Diagnostic Admission History dated 8/17/90. Interim Social Histor are present in the chart dated 8/17/90, 3/89, and 10/88. A Mental Status Exam is pres from the prior MSH admission dated 5/89. Psychiatric Evaluations are present dated 8/21/90 and 9/89. There are records from the hospital admission prior to being sent t MSH. Liver function studies in this alcoholic patient are available from 9/90. Physician notes are regular and appear at least monthly.

8. Goals: Not specifically documented.

. Patient Education: Not specifically documented.

.0. Medication Record: Present.

Integration: Not specifically documented.

Comment: There really is no good justification in the chart to the use of the buspirone in t patient. Anxiety presumably is a symptom of the underlying schizoaffective disorder and should, therefore, respond with appropriate medications for that disorder.

MEDICATION CHECKLIST

UMBER:	5-36716	DIAGNOSIS:	Schizophrenia, chronic, undifferentiated
DMISSION:	10-26-77		Diabetes mellitus, Type I
ITE:	Warren 42		
IRTHDATE:	10-11-50		
		MEDICATIONS:	chlorpromazine
			insulin
			docusate calcium (Surfak)
			erythromycin
			Bactracin ointment
			benztropine (Cogentin)
			acetaminophen

ISTORY:

1. Medication: Not Documented

. Allergy/Adverse Drug Reaction: Documented as no known allergy in appropriate locations

. Drug Abuse: Not documented

URRENT MEDICATIONS

. Indications: Chlorpromazine is an antipsychotic used to treat the symptoms of chizophrenia. Benztropine is an anticholinergic agent used to treat extrapyramidal adverse effects from chlorpromazine; there is no indication of such adverse effects in the patient an he benztropine is appropriately prescribed on an as needed basis. Insulin is used to treat he hyperglycemia associated with diabetes. Docusate is a stool softener used to prevent onstipation which may be a problem in association with antipsychotic agents. Erythromycin i an oral antibiotic and Bacitracin is a topical antibiotic ointment; their specific purpose is ot clear in the patient, although directions for the Bacitracin suggest they are being used reat a leg sore. Acetaminophen is a mild pain reliever being used as needed for general pai

. Contraindications: None documented.

. Drug Interactions: No specific adverse drug-drug interactions are documented.

. Adverse Drug Reactions: None documented.

. Dosage: All dosages are within acceptable limits.

. Prescriber: Clearly identified.

. Review: Last Annual Physical is dated 2/89 and Social History Update is dated 2/90. L. Psychological Update is dated 2/86. There is hospital admission records from an admiss to Galen in 10/89 for diabetes control. There are regular physician progress notes and monthly medication review. A chlorpromazine serum level ordered 11/20/90 was less than mcg/ml (normal range 50-300 mcg/ml); the dose was increased after receipt of the serum level. Patient has received extensive blood sugar monitoring and was seen in medical clinic every two weeks. Glycosolated hemoglobin levels are present from May, June, and July and indicate overall control of the diabetes is good.

. Goals: Not specifically documented.

. Patient Education: Not specifically documented.

0. Medication Record: Present.

ntegration: Not specifically documented.

Comment: Certainly the blood sugar control at a point in time for this patient is highly variable. The patient refuses to follow any dietary measures and predictably this results in yo-yoing of blood sugars. At the end of October, it was decided to stop Glucometer tests unless hypoglycemia is suspected or the patient is ill. Four times daily glucometer readings will be obtained 2 days before, and a fasting blood glucose on the day of a clinic visit. Th plan seems entirely appropriate in light of glycosolated hemoglobin readings which indicate overall control of glucose over a period of time; these readings have indicated overall gluco control is good. It appears continued periodic monitoring of this laboratory test would yiel the most valuable information in the care of this patient.

There was no physician progress note which addressed the need or purpose of the 10-day course of erythromycin or the Bacitracin ointment ordered on 11/22/90.

MEDICATION CHECKLIST

UMBER: 5-53142
DMISSION: 3-15-90
ITE: Warren 43
IRTHDATE: 12-11-61

DIAGNOSIS: Schizophrenia, paranoid, chronic
S/P suicide gesture

MEDICATIONS: clozapine (Clozaril)
aspirin
acetaminophen
ibuprofen (Motrin)
diphenhydramine
antacid

ISTORY:

1. Medication: Fairly good medication history is present on the Social History; patient h received ineffective trials with antipsychotic agents haloperidol, trifluoperazine, and fluphenazine. Also with lithium which gave an incomplete response.

2. Allergy/Adverse Drug Reaction: Documented as no known allergy inside chart; no allergy status documentation on outside of chart.

3. Drug Abuse: Documented as not present on the Social History.

URRENT MEDICATIONS

1. Indications: Clozapine is an atypical antipsychotic agent used in the treatment of efractory cases of schizophrenia. The documentation of unsuccessful trials with many othe ntipsychotics indicate its use is appropriate in the patient. All other medications are prescribed on an as needed basis. Aspirin and acetaminophen are being used for minor pain, buprofen is being used for dysmenorrhea, diphenhydramine is being used for insomnia, and ntacid for indigestion/heartburn. None of the agents are being used on a regular or even frequent basis.

. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

. Adverse Drug Reactions: Tachycardia with heart rates between 96-120 has been recorded association with clozapine in the patient; approximately 15-20% of patients receiving t drug suffer the effect. The patient is complaining of excessive salivation; this is a unique adverse effect of clozapine which occurs in 10-15% of patients.

. Dosage: All dosages are within acceptable limits.

. Prescriber: Clearly identified.

. Review: There is a medical history taken during admission and a Social History dated 3/19/90. There is a Diagnostic report from 3/19/90; no Mental Status exam is present. White blood counts are being conducted weekly during therapy with clozapine as is requi for the drug; baseline renal and liver function studies were preformed. There also is discharge summary from the hospital from which the patient was transferred to MSH.

. Goals: Not specifically documented.

. Patient Education: Not specifically documented.

0. Medication Record: Present.

Integration: Not specifically documented.

Comments: Use of clozapine seems entirely appropriate in the patient; at present, response could be qualified as "partial" into which 60% of patients given the drug are eventually classified.

MEDICATION CHECKLIST

UMBER: 5-21989
DMISSION: 7-3-87
ITE: Warren 41
IRTHDATE: 3-17-35

DIAGNOSIS: Schizophrenia, chronic, undifferentiated

MEDICATIONS: fluphenazine (Prolixin decanoate)
mesoridazine (Serentil)
benztropine (Cogentin)
Fibercon
Tinactin foot powder
aspirin
acetaminophen

ISTORY:

1. Medication: Not specifically documented although noted by physician that review of previous medication records seems to indicate that "nothing works."

2. Allergy/Adverse Drug Reaction: Documented as no known allergies.

. Drug Abuse: None according to Admission history, but patient is non-communicative.

URRENT MEDICATIONS

. Indications: Fluphenazine and mesoridazine are antipsychotic agents used to lessen the symptoms of the schizophrenia. Benztropine is an anticholinergic agent used to treat xtrapyramidal adverse effects of antipsychotic agents; none have been documented in the atient and benztropine was changed from a scheduled to as needed basis in early November. Fibercon is used to prevent constipation. Tinactin is an antifungal foot powder and aspirin nd acetaminophen are mild pain relievers; all are being used on an as needed basis.

2. Contraindications: None documented

Drug Interactions: No specific adverse drug-drug interactions are documented.

. Adverse Drug Reactions: Patient complains of drowsiness which she attributes to the Prolixin.

. Dosage: All dosages are within acceptable limits.

Prescriber: Clearly identified.

. Review: The most recent treatment plan review is dated 5/88. There is a Social History Update dated 11/88 and a Mental Status Exam from 9/27/90. The patient has an abnormal E which is monitored yearly while on antipsychotic agents. Thyroid and chemistry panels were normal in 11/90. Patient refuses annual physical. There are regular physician notes.

. Goals: Not specifically documented.

Patient Education: Not specifically documented.

0. Medication Record: Present.

ntegration: Not specifically documented.

mments: Patient is non-communicative and will not cooperate with physical, etc. While she ppears to be a candidate for therapy with clozapine, she will not take oral medication and his probably prohibits a trial with the new agent. A physician progress note suggests the edication is being considered. The concurrent use of two antipsychotic agents could also be

questioned in the patient in consideration of the apparent marginal response to existing agents. The anticholinergic therapy was appropriately converted from scheduled to as needed use.

MEDICATION CHECKLIST

UMBER:	5-46745	DIAGNOSIS:	Schizophrenia, chronic, undifferentiated
DMISSION:	12-8-89		Pregnant
ITE:	Warren 41		
IRTHDATE:	11-7-57		
		MEDICATIONS:	trifluoperazine (Stelazine)
			clonazepam (Klonopin)
			benztropine (Cogentin)
			prenatal vitamin
			aspirin
			acetaminophen

ISTORY:

1. Medication: Not Documented; patient was taking Stelazine & Cogentin prior to present admission.

2. Allergy/Adverse Drug Reaction: Documented as no known allergies.

3. Drug Abuse: Old Social History notes both past alcohol and drug abuse.

URRENT MEDICATIONS

1. Indications: Trifluoperazine is an antipsychotic agent used to control the symptoms of schizophrenia. Benztropine is an anticholinergic agent used for treatment of extrapyramidal symptoms which commonly result from treatment with antipsychotic agents. Clonazepam is a benzodiazepine most commonly used in the treatment of seizure disorders, but also may be used to treat anxious symptoms associated with underlying disorders; its purpose in this patient i not elucidated in the chart. Prenatal vitamins provide basic vitamin supplementation in addition to higher doses of folic acid required for fetal growth. Aspirin and acetaminophen are minor pain relievers being prescribed on an as needed basis.

2. Contraindications: The presence of pregnancy is a relative contraindication to the use many drugs. The safety of phenothiazine antipsychotics during pregnancy is not established, but it would appear that the benefit would outweigh the risk of stopping th agent for this patient. That does not necessarily appear to be the case for clonazepam and benzodiazepines are known teratogens; the need for this agent should be re-evaluatec Anticholinergic agents are not known teratogens, but the possibility of converting benztropine to as needed basis should be considered. Aspirin use should be avoided in t third trimester.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented, although the use of benztropine on a schedulec basis implies extrapyramidal adverse effects have occurred with trifluoperazine.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: A Mental Status Exam is present from 4/19/90 and a Psychiatric Evaluation is dated 8/13/90. A Social History is dated 12/19/89 and a Psychosocial History is dated 8/2/89. A chemistry panel in 9/90 was normal and the pregnancy was confirmed in 11/90 b both urine and blood tests. Physician notes appear on a regular basis.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

:tegration: Not specifically documented.

Comments: See discussion in "Contraindications." The need for the benzodiazepine should be documented if the agent is continued in this pregnant patient. The patient is noted to be noncompliant with medication when in the community.

MEDICATION CHECKLIST

UMBER: 4-37687
DMISSION: 12-4-80
ITE: High security
IRTHDATE: 6-11-58

DIAGNOSIS: Schizophrenia, catatonic type
Organic mental disorder
Epilepsy, tonic-clonic

MEDICATIONS: trifluoperazine (Stelazine)
thioridazine (Mellaril)
trihexyphenidyl (Artane)
Sustacal
Selsun shampoo
aspirin
acetaminophen
antacid
ibuprofen (Motrin)

ISTORY:

. Medication: Not specifically documented; available on admission history.

. Allergy/Adverse Drug Reaction: Documented as no known allergies.

. Drug Abuse: Extensive history of drug abuse, including PCP.

URRENT MEDICATIONS

1. Indications: Trifluoperazine and thioridazine are antipsychotic agents used to control he symptoms of schizophrenia; the patient has received the dual-drug therapy for a prolonged eriod of time. Trihexyphenidyl is an anticholinergic agent used to treat extrapyramidal dverse effects from the antipsychotic agents; the need for continuous agent is not documente ustacal is a nutritional supplement and selsun shampoo is used to control dandruff. Aspirin cetaminophen, and ibuprofen are pain relievers being used on an as needed basis; the ibuprof is being used in anti-inflammatory doses to treat arm pain. The antacid is being used as eeded for indigestion.

Contraindications: None specifically documented, although the present of a seizure disorder is a relative contraindication to the use of antipsychotic agents which are kn to lower seizure threshold.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: The use of Artane suggest prior problems with extrapyramidal adverse effects from antipsychotic agents. The patient was taken to medical clinic in 6/88 for hypotension attributed to the antipsychotic agents.

Dosage: All dosages are within acceptable limits.

Prescriber: Clearly identified.

. Review: The most recent documentation is the Mental Status Exam is 5/85. The last Ann Physical was 5/88; it is documented that patient refused physical in 7/90. A Social History dated 12/80 is present. An EKG was dated 5/88. It was noted that no physician notes appeared in the patient chart from 7/13/90 to 10/4/90.

Goals: Not specifically documented.

. Patient Education: Not specifically documented.

. Medication Record: Present.

tegration: Not specifically documented.

:mment: The patient has a history of assaultive behavior and inappropriate sexual touching
he patient was transferred from Low to High security on 11/28 for inappropriate sexual
behavior toward female staff; documentation is present. However, the lack of physician note
for a 3 month period also is notable. Although patient is listed as having seizure disorde
anticonvulsant medication was discontinued in 12/87 after obtaining a normal EEG; no seizure
have occurred since the discontinuation.

MEDICATION CHECKLIST

NUMBER:	4-49208	DIAGNOSIS:	Schizophrenia, paranoid
ADMISSION:	1-6-89		Alcoholism
SITE:	Medium security		Cannabis abuse
BIRTHDATE:	11-24-62		
		MEDICATIONS:	loxapine (Loxitane)
			carbamazepine (Tegretol)
			propranolol (Inderal)
			benztropine (Cogentin)
			acetaminophen
			antacid

HISTORY:

1. Medication: Not Documented

2. Allergy/Adverse Drug Reaction: Documented as no known allergies.

3. Drug Abuse: Extensive alcohol & drug abuse documented.

CURRENT MEDICATIONS

1. Indications: Loxapine is an antipsychotic agent used to control symptoms of schizophrenia. Benztropine is an anticholinergic agent used to treat extrapyramidal adverse effects from antipsychotic agents; it is being used regularly in the patient. Carbamazepine an anticonvulsant and propranolol is an antihypertensive agent. However, each agent has been found to be useful in the treatment of behavior disorders, including aggression. The acetaminophen is a mild pain reliever and antacid is used for indigestion on an as needed basis.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: Several notes of patient pacing which may represent akathisia, extrapyramidal adverse effect from the loxapine.

5. Dosage: All dosages are within acceptable limits, although the dosage of propranolol is below the dose typically used for behavior disorders.

6. Prescriber: Clearly identified.

7. Review: The most recent Mental Status is dated 9/90 and an Interim Social History is dated 1/89. Monthly Tegretol levels have been obtained on a monthly basis, and regular white blood cell counts are being obtained. An EKG is dated 8/90.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

Comment: The dose of propranolol is very low and should be evaluated as to its contribution behavior control. Also, the serum levels for carbamazepine are low for the treatment of behavior; the dose could be increased if desired. The use of scheduled anticholinergic therapy seems justified in this patient due to the presence of akathisia. The patient is in security because he attempts escape when transferred to an unsecured area.

MEDICATION CHECKLIST

NUMBER:	3-53313	DIAGNOSIS:	Schizophrenia, paranoid, chronic
ADMISSION:	10-3-90		Post-traumatic stress disorder
SITE:	A Ward		
BIRTHDATE:	3-29-58		
		MEDICATIONS:	haloperidol (Haldol)
			benztropine (Cogentin)
			multivitamin
			acetaminophen
			aspirin

HISTORY:

1. Medication: Not documented, but no medication taken prior to admission.

2. Allergy/Adverse Drug Reaction: Documented as no known allergies

3. Drug Abuse: No drug abuse, occasional alcohol use documented.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent used to control the symptoms of schizophrenia. Benztropine is an anticholinergic agent used to treat extrapyramidal adverse effects of haloperidol. The multivitamin is a nutritional supplement and aspirin and acetaminophen are mild pain relievers being used as needed.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: Several effects are documented which may represent extrapyramidal adverse effects of haloperidol. These include flat facial expression, what is described as "bloating" by the patient, and muscle stiffness.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The History and Physical is dated 10/3/90 and a Interim Social History is dated 10/9/90. There is a Psychiatric Evaluation dated 10/5/90 and records from the previous MSH admission are present, including a Social History dated 5/90. An EKG and thyroid panel are present and normal.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

Comment: Transfer to C Ward is being considered; patient is oppositional and uncooperative with a lack of insight. Patient is high risk for noncompliance; she states a dislike for medication; in this respect, use of scheduled benztropine seems justified since adverse symptoms are suggestion of extrapyramidal adverse effects.

MEDICATION CHECKLIST

UMBER: 4-53853
DMISSION: 11-1-90
SITE: A Ward
BIRTHDATE: 2-18-42

DIAGNOSIS: Bipolar affective disorder, manic

MEDICATIONS: lithium carbonate
haloperidol (Haldol)
benztropine (Cogentin)
aspirin
acetaminophen

HISTORY:

1. Medication: Patient receiving lithium prior to admission.

2. Allergy/Adverse Drug Reaction: Documented as no known allergies.

3. Drug Abuse: Documented as no alcohol or drug abuse

CURRENT MEDICATIONS

1. Indications: Lithium is an antimanic agent used to treat the underlying bipolar disorde the patient has a long history of bipolar disorder and a documented response to lithium despi occasional relapses. Haloperidol is an antipsychotic agent frequently used during the acute phase of bipolar disorder to control symptoms of agitation and excitability. Benztropine is anticholinergic agent used to treat extrapyramidal adverse effects associated with haloperido therapy. Aspirin and acetaminophen are mild pain relievers being used on an as needed basis.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented, although there may be additive central nervous system depression with lithium and haloperidol.

4. Adverse Drug Reactions: Patient has complained of nausea and vomiting which are common adverse effects of higher dose lithium therapy required during the acute bipolar attack; serum lithium concentrations confirmed serum levels at the time were non-toxic but in th upper range of normal. The patient also reports that haloperidol makes him sleepy and causes dry mouth; the dry mouth likely is related to benztropine. The History & Physica notes tremors which could be an adverse effect of lithium and elevated white blood cell counts also could be related to chronic lithium therapy. A nurse's note on 11/6 mention extrapyramidal adverse effects, common with haloperidol; unfortunately, non-definitive therapy with lorazepam was used to treat the effects at that time.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: A Psychiatric Evaluation is dated 11/7/90 and a Social History is dated 11/8/90 Thyroid function studies are normal and lithium serum concentrations are being monitored and kept within the desired range for clinical benefit. Physician progress notes appear on a regular basis.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

omment: The use of antipsychotic agents as adjunctive therapy with lithium during acute
ipolar attack is well accepted; the haloperidol should be tapered and withdrawn as the pati
esponds.

MEDICATION CHECKLIST

UMBER: 3-50531
DMISSION: 10-19-90
ITE: A Ward
BIRTHDATE: 4-16-36

DIAGNOSIS: Schizoaffective disorder
Organic brain syndrome

MEDICATIONS: haloperidol (Haldol)
lithium carbonate
benztropine (Cogentin)
lorazepam (Ativan)
naproxen (Naprosyn)
multivitamin w/ minerals
fibercon

ISTORY:

1. Medication: Documented in admission record that patient was taking same medications pr to admission.

2. Allergy/Adverse Drug Reaction: Multiple allergies- to penicillin, fluphenazine, carbamazepine, and codeine noted on MAR and physician's order form. However, only the allergy to penicillin was noted on allergy tape on front of chart.

3. Drug Abuse: Not documented

URRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent and lithium carbonate is an antiman gent; these are being used to control the symptoms of the schizoaffective disorder. Benztropine is an anticholinergic agent used to treat extrapyramidal adverse effects which commonly occur with haloperidol. Lorazepam is a benzodiazepine antianxiety agent; its purpos n the patient is not clear although its use at bedtime suggests it is being used to enhance leep. Similarly, naproxen is an antiinflammatory/analgesic agent whose purpose in the patie is not clear. The multivitamin is being used as a nutritional supplement.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: The physician in the History and Physical noted a shuffling ga and wormlike movements of the tongue. The former symptom is suggestive of extrapyramid adverse effects from the haloperidol, while the latter symptom is suggestive of mild tardive dyskinesia; however, mention of the symptom was not present in subsequent notes. The patient has constipation which could be caused in some part by the regular use of a anticholinergic agent.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: A Mental Status Exam is dated 7/90 and a Psychiatric Evaluation is dated 5/90, is an Interim Social History. Serum concentrations for both haloperidol and lithium ha been recently measured and are within a range associated with therapeutic benefit. Ren function studies are pending and thyroid studies are normal.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

Comment: The patient does poorly as an outpatient. She has been considered for treatment w Clozaril, but has been rejected in consideration of questionable medication compliance as an outpatient. The process of evaluation for Clozaril appears to have been well conducted and t conclusion reached appears justified and correct.

MEDICATION CHECKLIST

NUMBER: 4-37651
ADMISSION: 10-6-89
UNIT: D Ward
BIRTHDATE: 2-25-54

DIAGNOSIS: Schizoaffective disorder
Alcoholism
Substance abuse

MEDICATIONS: fluphenazine (Prolixin)
trihexyphenidyl (Artane)
lorazepam (Ativan)
multivitamin
diphenhydramine (Benadryl)
aspirin & acetaminophen

HISTORY:

1. Medication: Patient was taking fluoxetine previously; there is documented of good cont with fluphenazine and trihexyphenidyl previously.

2. Allergy/Adverse Drug Reaction: Documented as allergic to penicillin & sulfa

3. Drug Abuse: Positive for both alcohol and drug abuse.

CURRENT MEDICATIONS

1. Indications: Fluphenazine is an antipsychotic agent used to control the symptoms of th schizoaffective disorder. Trihexyphenidyl is an anticholinergic agent used to treat extrapyramidal adverse effects which can occur with fluphenazine. Lorazepam is a benzodiazepine antianxiety agent; its purpose in the patient is not clear. The multivitamin is nutritional supplement. Diphenhydramine is an antihistamine being used on an as needed bas for insomnia, and aspirin and acetaminophen are mild pain relievers being used as needed for pain.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The admission History and Physical is dated 10/6/89 and a Psychosocial History dated 10/9/89. A Psychiatric Evaluation is dated 10/11/89. Physician notes appear on a regular basis and a Mental Status Update is written to the physician progress notes on 11/16/90.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

Comment: ? need/use of lorazepam, especially in patient with history of substance abuse.

MEDICATION CHECKLIST

NUMBER: 3-53742
ADMISSION: 9-27-90
SITE: D Ward
BIRTHDATE: 7-6-72

DIAGNOSIS: Borderline personality disorder
Borderline intellectual function
Acne

MEDICATIONS: haloperidol (Haldol)
fluoxetine (Prozac)
trazodone (Desyrel)
oral contraceptive
Benzac WC ointment
acetaminophen
ibuprofen (Motrin)

HISTORY:

1. Medication: Documented as being on triple-drug therapy with haloperidol, fluoxetine, a trazodone prior to admission; no extensive medication history.

2. Allergy/Adverse Drug Reaction: Documented as allergic to penicillin and codeine; howev the documentation DOES NOT appear on outside of chart.

3. Drug Abuse: Documented as no drug abuse and only occasional alcohol use.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent and fluoxetine and trazodone are bo antidepressant agents which primarily affect the neurotransmitter serotonin. The specific purpose of any of the agents is not clear, although they are presumably being used to decrea manifestations of the personality disorder. Benzac WC is a medication used to prevent exacerbations of acne. Acetaminophen is a mild pain reliever and ibuprofen is an anti-inflammatory/analgesic agent; both are being used on an as needed basis.

2. Contraindications: None specifically documented, although patient claimed to have had seizure in 9/90; antipsychotic agents lower the seizure threshold.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: Hospital admission notes are dated 9/90. Both a Psychiatric Evaluation and Social History are present dated 9/27/90. Thyroid function studies have been performed and are normal and an EKG was obtained 9/90. An EEG also was obtained 9/90 after the patient claimed to have suffered a seizure. Physician notes appear at regular interval

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.
Integration: Not specifically documented.

Comment: While the use of antidepressant and antipsychotic medications is common to control symptoms of patients with personality disorders, the need for the use of the two antidepressants fluoxetine and trazodone is not justified by documentation in this patient. Nor does the combination appear rational since each agent primarily affects serotonin neurotransmission. The dosage for neither agent is maximized.

MEDICATION CHECKLIST

UMBER: 2-38156
DMISSION: 1-10-85
ITE: Medium security
BIRTHDATE: 11-18-55

DIAGNOSIS: Schizoaffective disorder
Epilepsy, tonic-clonic
water intoxication

MEDICATIONS: haloperidol (Haldol)
trihexyphenidyl (Artane)
phenytoin (Dilantin)
simethicone (Mylicon)
benzyl peroxide
acetaminophen
dandruff shampoo

ISTORY:

. Medication: Not Documented

Allergy/Adverse Drug Reaction: Documented as no known allergies.

. Drug Abuse: Not documented

URRENT MEDICATIONS

Indications: Haloperidol is an antipsychotic agent which controls the symptoms of the chizoaffective disorder. Trihexyphenidyl is an anticholinergic agent being used to prevent extrapyramidal adverse effects which commonly occur with haloperidol. Phenytoin is an nticonvulsant agent used to prevent seizures. Simethicone is an anti-gas agent; its specifi rpose in the patient is not clear. Benzyl peroxide treats and prevents exacerbations of cne. Acetaminophen is a mild pain reliever being used on an as needed basis.

Contraindications: The presence of a seizure disorder in a patient receiving antipsychotic agents is a relative contraindication since the agents lower the seizure threshold. However, the benefit outweighs the risk in this case.

Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: None specifically documented. Patient has suffered seizures which probably are caused by water intoxication, but haloperidol could be a contributing factor.

Dosage: All dosages are within acceptable limits.

Prescriber: Clearly identified.

Review: Only recent documentation present is an Annual Physical dated 2/89. Patient electrolytes are monitored every two weeks in consideration of water intoxication and patient is weighed twice daily. Phenytoin serum concentration is being monitored every three months and levels are present which are associated with therapeutic benefit. Ther are regular physician notes.

Goals: Not specifically documented.

Patient Education: Not specifically documented.

. Medication Record: Present.

tegration: Not specifically documented.

omment: Patient well documented as problem with regard to water intoxication. Seclusion p
s in place which involves twice daily weights and seclusion based on a weight gain of four
ounds. Patient is removed from seclusion when electrolytes are normal. Interesting physic
rder on 10/10/90 to discontinue lithium; patient was not receiving the drug.

MEDICATION CHECKLIST

UMBER:	4-42580	DIAGNOSIS:	Antisocial personality disorder
DMISSION:	11-2-90		Adrenoleukodystrophy w/ dementia
ITE:	High security		Paraphilia, mixed
IRTHDATE:	12-19-59		Epilepsy
			Adrenal insufficiency
		MEDICATIONS:	fludrocortisone (Florinef)
			prednisone
			phenobarbital
			B-complex vitamin
			acetaminophen

ISTORY:

1. Medication: Not specifically documented, but patient has received phenytoin in past for seizure disorder.

2. Allergy/Adverse Drug Reaction: Documented as no known allergies.

3. Drug Abuse: Some history of alcohol use, but no drug abuse.

URRENT MEDICATIONS

1. Indications: Fludrocortisone is a mineralcorticoid and prednisone is a glucocorticoid; oth are being used for treatment of the congenital adrenal disorder. Phenobarbital is an nticonvulsant agent being used for the seizure disorder and B-complex vitamin is a nutrition pplement. Acetaminophen is a mild pain reliever being used on an as needed basis.

2. Contraindications: None documented

3. Drug Interactions: Barbiturates including phenobarbital have been shown to enhance the metabolism of corticosteroids including prednisone; larger doses of the steroid may be required to achieve the desired effect.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: A Diagnostic Report, History and Physical, and Interim Social History are all available and dated in 11/90. The discharge summary from MSH in 1988 also is present an a Mental Status exam is dated 8/88. The are weekly electrolyte and liver function test results; liver studies demonstrate an increase LDH and gamma-GT which are probably due t phenobarbital therapy. Patient has a documented positive PPD test and received a one-year course of prophylactic therapy with isoniazid for tuberculosis in 1989. A thyroid panel is normal and phenobarbital serum level is within the range associated with therapeutic benefit.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

ntegration: Not specifically documented.

comment: The diagnosis of a seizure disorder in the patient appears to be based on a seizure which occurred in 1988 in association with alcohol withdrawal. Such seizures do not constitute a diagnosis of epilepsy and do not justify prophylaxis with anticonvulsant medication. The diagnosis of epilepsy needs further/better documentation in this case. In the presence of ataxia and motor incoordination with the adrenal disorder, the discontinuation of phenobarbital, if justified, could offer significant patient benefit.

MEDICATION CHECKLIST

NUMBER:	4-36232	DIAGNOSIS:	Schizophrenia
ADMISSION:	5/25/81		Smoker
SITE:	Warren 43		Aggression
BIRTHDATE:	6/1/53		

MEDICATIONS:
Benzoyl peroxide
Selenium sulfide shampoo (Selsun^{R})
Clozapine (Clozaril^{R})
Psyllium (Metamucil^{R})
Diphenhydramine (Benadryl^{R})
Antacid liquid
Aspirin
Acetaminophen (Tylenol^{R})
Tetrahydrozoline (Visine^{R})
Ibuprofen (Motrin^{R})
Throat lozenge (Chloraseptic^{R})
Clorazepate (Tranxene^{R})

HISTORY:

Medication: Psychotropic medications are documented on the physical examination dated 9/14/90.

Allergy/Adverse Drug Reaction: Allergies are documented on the medication administration record; past adverse drug reaction are not documented.

Drug Abuse: Documented in the physical examination.

CURRENT MEDICATIONS

Indications: Benzoyl peroxide is a topical which was used to treat facial acne lesions. Selenium sulfide shampoo is an antidandruff shampoo; dandruff is not specifically documented. Clozapine is an antipsychotic agent which was used to control some of the manifestations of schizophrenia and to control aggressive behavior. It appears to have been more effective than previous antipsychotic agents. Psyllium is an bulk-forming laxative which is presumably used to treat constipation. Diphenhydramine is a sedating antihistamine which was prescribed as needed for insomnia. Antacid liquid was prescribed as needed for indigestion. Aspirin and acetaminophen were prescribed as needed for pain. Tetrahydrozoline eyedrops were prescribed as needed for eye irritation. There is no documentation of this irritation. Ibuprofen was prescribed as needed for menses pain. The throat lozenges were used as needed for sore throat. There is no documentation of the nature of this sore throat. Clorazepate is an antianxiety agent and was prescribed on 10/23/90 because of increased agitation. It was discontinued on 11/1/90 due to no response.

2. Contraindications: None documented

Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 3/19/86. The most recent annual physical examination is dated 9/14/90; the most recent mental status examination is dated 4/19/84. There was an outside consultation regarding parotitis on 8/20/90. There have been monthly physician progress notes during recent months. This person has demonstrated refractoriness to numerous agents, but appears to be getting at least some response to clozapine. Since there were three different psychiatrist within a three months period it is difficult to draw valid conclusion. The most recent note on 11/2/90 suggests that symptoms have yet to be adequately controlled.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER: 5-36977
ADMISSION: 4/15/88
SITE: Montana State Hospital
BIRTHDATE: 5/10/26

DIAGNOSIS: Schizophrenia
Smoker

MEDICATIONS: Docusate sodium (Diocto^{R})
Doxepin (Sinequan^{R})
Loxapine (Loxitane^{R})
Benztropine (Cogentin^{R})
Mesoridazine (Serentil^{R})
Artificial Tears
Diphenhydramine (Benadryl^{R})
Acetaminophen (Tylenol^{R})
Aspirin
Diphenhydramine and calamine lotion (Caladryl^{R})
Hydrocortisone ointment
Lorazepam (Ativan^{R})
Clozapine

HISTORY:

1. Medication: Psychotropic medications are documented on the Medication History Form which is not dated.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; the physical examination states that psychotropics usually cause her vision problems.

3. Drug Abuse: Documented on the Medication History Form.

CURRENT MEDICATIONS

1. Indications: Docusate is a stool softener presumably used to treat or prevent constipation. Doxepin is an antidepressant; its specific use is not documented. Loxapine is an antipsychotic agent used to treat and suppress the manifestation of schizophrenia. Benztropine is an anticholinergic agent used to prevent or treat the extrapyramidal side effects of the antipsychotic. It is usually not necessary to continue this agent long-term in the absence of continued side effects. Mesoridazine is an antipsychotic agent also. It was prescribed as needed either po or IM for agitation or psychotic behavior. It is usually better to use a single agent rather than combine antipsychotic agents. There is no documentation for the artificial tears. Diphenhydramine is a sedating antihistamine which was prescribed for insomnia. Acetaminophen and aspirin were prescribed as needed for pain. Diphenhydramine and calamine is a lotion used to treat a rash as needed. Hydrocortisone ointment is a topical antiinflammatory agent used to treat a rash. Lorazepam is an antianxiety agent prescribed to be given intramuscularly each time she refuses clozapine at regular medication time. Its indication is not clear. Clozapine is an antipsychotic agent which was recently substituted for the other antipsychotic due to lack of efficacy.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: The physical examination documents vision problems from antipsychotic in the past.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 8/20/90. The most recent annual physical examination is dated 1/22/90. The most recent social history is dated 3/11/77, 4/26/86, and 9/27/89. There was no outside consultations but several referrals this past year to medication clinic deal with rashes, eye problems, weight loss, toe injury and abdominal pain. There have been monthly physician progress notes recently. The Clozaril Screening Committee documented review on 7/13/90 prior to beginning clozapine. Weekly white blood cell counts and other laboratory data for monitoring clozapine has been performed. There has been some improvement.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

Comment: The order for lorazepam IM when ever the patient refuses clozapine seemed punitive on the surface.

MEDICATION CHECKLIST

NUMBER:	2-37985	DIAGNOSIS:	Schizophrenia
ADMISSION:	9/26/90		Neurogenic bladder
SITE:	Montana State Hospital		Hydronephrosis
BIRTHDATE:	12/16/55		History of noncompliance

MEDICATIONS:
Lorazepam (Ativan^{R})
Ranitidine (Zantac^{R})
Acetaminophen (Tylenol^{R})
Benztropine (Cogentin^{R})
Thiothixene (Navane^{R})
Throat Lozenge
Erythromycin
Clozapine
Diflunisal (Dolobid^{R})

HISTORY:

1. Medication: Documented on the Medication History Form dated 9/26/90, the transfer records from the acute care hospital and the social history.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Documented on the Medication History Form and the social history.

CURRENT MEDICATIONS

1. Indications: Lorazepam is an antianxiety agent which was prescribed to be given orally or intramuscularly as needed for agitation or extreme tension. Ranitidine is an H2-antihistamine which was used as needed for stomach symptoms. Acetaminophen was prescribed as needed for headache. Benztropine ia an anticholinergic agent. It was presumably prescribed to treat or prevent extrapyramidal side effects from the thiothixene, but this latter agent has been discontinued. Its continued need is not documented. Thiothixene is an antipsychotic agent used to suppress some manifestation of schizophrenia. It was tapered and discontinued on 11/25/90 when clozapine was substituted because of lack of efficacy. Throat lozenges were prescribed as needed for sore throat. Erythromycin is an antibiotic. Its need is not documented. There is no physician note on that date and the nurses notes do not identify its need. There was a chest x-ray that day but no interpretation is provided in the ward record. It was discontinued on 10/12/90 after eight days. Diflunisal is an antiinflammatory/analgesic agent which was prescribed for pain associated with a bruise on the arm.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: There is no treatment plan in the ward record. The most recent Psychiatric evaluation is dated 9/27/90; the most recent social history is dated 9/27/90 . The was an outside consultation regarding on 10/18/90 regarding the neurogenic bladder which suggested bethanechol, but this drug has not been ordered. There were also medical clinic referrals in 1990. There have been eight physician progress notes in the last three months, most recently 11/13/90. The Clozaril Screening Committee meetin is documented on 10/18/90. Weekly white blood cell counts and other lab data have been obtained in the monitoring of clozapine.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER:	5-45456	DIAGNOSIS:	Idiopathic Hypertrophic Subaortic Stenosis
ADMISSION:	9/26/86		
SITE:	Montana State Hospital		Smoker
BIRTHDATE:	12/21/62		Schizophrenia

MEDICATIONS: Haloperidol (Haldol^{R})
Acetaminophen (Tylenol^{R})
Multiple vitamin
Docusate calcium (Surfak^{R})
Verapamil (Calan^{R})
Carbamazepine (Tegretol^{R})
Lithium

HISTORY:

1. Medication: Documented on the Medication History Form date 9/26/86

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Documented on the Medication History Form.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent which was used to suppress the manifestation of schizophrenic. It was also prescribed as needed for agitation. Acetaminophen was prescribed as needed for pain. Docusate is a stool softener which was presumably prescribed to treat or prevent constipation. Benztropine is an anticholinergic agent which was presumably used to treat or prevent extrapyramidal side effects from haloperidol. There are no such effects documented. It is usually not necessary to continue the anticholinergic agent long term in the absence of continued side effects. Verapamil is a calcium flux antagonist which was used to decrease contractility in the setting of idiopathic hypertrophic subaortic stenosis. Carbamazepine is an anticonvulsant. There is a previous diagnosis of schizoaffective disorder and also a hint of a behavior problem which might be the indication of this agent as well as the lithium, but the exact indication is not specifically documented.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. Serum carbamazepine and lithium concentration have been within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 3/29/90. The most recent annual physical examination was refused on 1/14/89. The most recent Psychiatric evaluation is dated 10/6/86; the most recent social history is dated 12/9/87. The was a referral to medical clinic on 4/23/90. There have been monthly physician progress notes recently. It would seem that the anticholinergic should be tapered and discontinued. The need for lithium and carbamazepine should be documented.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER:	3-45227	DIAGNOSIS:	Schizophrenia, paranoid
ADMISSION:	5/4/85		Smoker
SITE:	Montana State Hospital		Borderline Intellectual functioning
BIRTHDATE:	6/4/63		

MEDICATIONS: Aspirin
Acetaminophen (Tylenol^{R})
Clozapine (Clozaril^{R})

HISTORY:

1. Medication: Documented on the Medication History Form dated 5/4/85 and the physical examination dated 5/10/89.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made os past adverse drug reactions.

3. Drug Abuse: Documented on the Medication History Form.

CURRENT MEDICATIONS

1. Indications: Aspirin and acetaminophen were prescribed as needed for pain. Clozapine is an antipsychotic agent which was used to suppress some of the manifestations of schizophrenia.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: There appears to be some question of tachycardia secondary to clozapine in the progress notes but this is not clear and it is not a continuing problem.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 7/13/90. The most recent annual physical examination is dated 6/5/90; the most recent mental status examination is dated 4/18/90; the most recent psychological evaluation is dated 7/13/90; the most recent social history is dated 6/25/90. There was medical consultation regarding tachycardia on 8/27/90. Physician progress notes recently have been sparse.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER:	4-33614	DIAGNOSIS:	Schizophrenia, paranoid with catatonic features
ADMISSION:	11/18/83		Smoker
SITE:	Montana State Hospital		Hip prothesis
BIRTHDATE:	11/20/40		

MEDICATIONS:
Ibuprofen (Motrin^{R})
Benzoyl peroxide (Benzagel^{R})
Acetaminophen (Tylenol^{R})
Penicillin VK
Thiothixene (Navane^{R})
Lithium
Benztropine (Cogentin^{R})

HISTORY:

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions

3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Ibuprofen was used for hip or foot pain. Acetaminophen was prescribed as needed for pain. It is not stated why there is a need to duplicate analgesics. Benzoyl peroxide was prescribed as needed for acne. The extent of acnes is not documented but use of this product as needed and in a middle aged women suggests that perhaps it is not needed. Penicillin V K was used before dental appointment because to prevent infection of the prosthetic hip. Thiothixene is an antipsychotic agent which was used orally to suppress some the manifestations of schizophrenia and intramuscularly as needed for agitation. Lithium was used adjunctively in the treatment of schizophrenia. Benztropine is an anticholinergic agent used to treat or prevent the extrapyramidal side effects from the thiothixene. Since there is no documentation of these side effects it may be possible to taper the dosage and eventually discontinue the benztropine. It is usually not necessary to continue the anticholinergic long term.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented. The progress note on 11/21/90 specifically stated a lack of tardive dyskinesia.

5. Dosage: All dosages are within acceptable limits. Serum lithium concentrations have been within the usual therapeutic range.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 4/26/90. The most recent annual physical examination is dated 5/4/90; the most recent psychological report is dated 10/8/86; the most recent Psychiatric evaluation is dated 12/2/83; the most recent social history is dated 3/26/90. The were medical consultations on 10/22/90, 9/25/90, 8/3/90, and 7/5/90 for minor medical problems. There have been monthly physician progress notes recently. A recent small reduction in dosage with plans for very slow further reduction is applauded. The need for benzoyl peroxide and benztropine should be reassessed..

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER: 2-36733
ADMISSION: 12/8/82
SITE: Montana State Hospital
BIRTHDATE: 1/12/58

DIAGNOSIS: Schizophrenia
Borderline mental retardation
Smoker
History of water intoxication

MEDICATIONS: Clozapine (Clozaril^{R})
Aspirin
Acetaminophen (Tylenol^{R})
Nutritional supplement (Sustacal^{R})
Trihexyphenidyl (Artane^{R})
Trifluoperazine (Stelazine^{R})
Lorazepam (Ativan^{R})

HISTORY:

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Documented on the Mental Status Examination dated 6/29/89.

CURRENT MEDICATIONS

1. Indications: Clozapine is an antipsychotic agent used to suppress some of the manifestation of schizophrenia. Prior to this new agent, the schizophrenia was treated with trifluoperazine, an antipsychotic agent, lorazepam, and antianxiety agent, and trihexyphenidyl, an anticholinergic agent. On 8/17/90, it was discovered that the patient had been spitting out his clozapine and therefore it was discontinued and the old regimen reinstituted. He deteriorated without the clozapine. Clozapine has since been tried again, but unsuccessfully due to compliance. Aspirin and acetaminophen were prescribed as needed for pain.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. There is no interval or daily dosage limit on the as needed acetaminophen.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 7/14/87. The most recent annual physical examination is dated 2/1/90; the most recent mental status examination is dated. There were medical consultations on 5/24/90, 5/31/90, 8/2/90, and 8/16/90. There have been monthly physician progress notes recently. The patients refusal to take clozapine and to attend treatment review clinic (11/27/90) have created a difficult situation. Aggressive outburst and psychotic manifestations (delusion, paranoia) restrict the individual to inpatient status. Given the better response

clozapine, it may be worth trying to convince the patient to give this drug another chance.

8. Goals: Not specifically documented.

Patient Education: Not specifically documented.

Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER:	5-53875	DIAGNOSIS:	Antisocial personality disorder
ADMISSION:	11/9/90		Alcohol abuse
SITE:	Montana State Hospital		Smoker
BIRTHDATE:	6/22/70		Alleged sexual assault
			history of hyperactivity
		MEDICATIONS:	Chlorpromazine (Thorazine^{R})
			Mesoridazine (Serentil^{R})

HISTORY:

1. Medication: Documented on the Medication History Form dated 11/9/90.

2. Allergy/Adverse Drug Reaction: Documented on the Medication Administration Record and the medical history form.

3. Drug Abuse: Documented on the Medication History Form.

CURRENT MEDICATIONS

1. Indications: Chlorpromazine and mesoridazine are antipsychotic agents. Chlorpromazine was continued on admission, but was tapered and discontinued on 11/15/90. Mesoridazine was used as needed for agitation and then change to a regular schedule on 11/15/90. The specific indication for these agents is not stated.

2. Contraindications: There was an intraventricular conduction defect on the electrocardiogram on 11/16/90. This represents a relative contraindication to the use of any antipsychotic agent. There has not been any problems noted in this case.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. There is no need to split the daily dosage of either antipsychotic.

6. Prescriber: Clearly identified.

7. Review: There is no treatment plan as this person was recently admitted for evaluation. The physical examination is not yet in the chart. The panel laboratory examination was normal and the electrocardiogram was present. There have not yet been any physician progress notes.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER:	4-38176	DIAGNOSIS:	Adjustment disorder with mixed emotional features
ADMISSION:	3/27/90		Antisocial personality disorder
ITE:	Montana State Hospital		Alcohol abuse
IRTHDATE:	7/28/64		Psychoactive substance abuse
		MEDICATIONS:	Thioridazine (Serentil^{R})
			Amitriptyline (Elavil^{R})
			Selenium sulfide shampoo (Selsun^{R})
			Fluphenazine decanoate (Prolixin^{R})
			Acetaminophen (Tylenol^{R})
			Antacid
			Diphenhydramine (Benadryl^{R})
			Doxepin (Sinequan^{R})
			Lithium

ISTORY:

1. Medication: The Medication History Form states "see previous admission".

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of previous adverse drug reactions.

3. Drug Abuse: Not documented.

URRENT MEDICATIONS

1. Indications: Thioridazine and fluphenazine are antipsychotic agents. There exact use is not documented in terms of a diagnosis, but there have been hallucinations documented in the notes. Fluphenazine decanoate, a long acting injectable, was substituted for thioridazine. Amantadine was used to treat or prevent extrapyramidal side effects from the antipsychotics. Amitriptyline and doxepin are antidepressants. Although there is no specific diagnosis of depression, depressive symptoms are reported regularly in the progress notes. On 11/19/90, doxepin was substituted for amitriptyline due to lack of response. Selenium sulfide shampoo is a dandruff shampoo. Acetaminophen was prescribed as needed for pain. Antacid was prescribed as needed for indigestion. Diphenhydramine was prescribed as needed for insomnia. The specific indication for lithium is not documented. The various diagnoses over the years and the lack of control of symptoms, suggests that a lithium trial would be justified.

2. Contraindications: None documented

   Drug Interactions: No specific adverse drug-drug interactions are documented.

   Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. The antidepressant dosage has been titrated to rather high levels. There is no reason to split the daily dosage of either the antidepressant or the antipsychotic.

6. Prescriber: Clearly identified.

7. Review: The is not a recent treatment plan in the chart. The physical examination is not in the chart. The most recent social history is date 3/29/90. The was a Montana State Hospital summary to the Prison dated 10/12/90 which state that this individual did not suffer from mental illness treatable at Montana State Hospital. There have been monthly physician progress notes recently. There is a nurses note (11/24/90) which states that lithium and doxepin best control his depression and anger. This case should be reviewed and a decision made as to where this person should be treated.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER:	4-47280	DIAGNOSIS:	Schizophrenia
ADMISSION:	2/1/85		Coronary artery disease
SITE:	Montana State Hospital		Smoker
BIRTHDATE:	5/24/41		History of allergy to all psychotropic medication
			MEDICATIONS:Aspirin
			Acetaminophen (Tylenol^{R})
			Nitroglycerine (Nitrostat^{R}, Nitrobid^{R})

ISTORY:

1. Medication: Not documented.

. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

. Drug Abuse: Not documented.

CURRENT MEDICATIONS

. Indications: Aspirin was originally prescribed as need for pain, but has since been changed to one daily. This regular schedule is for prevention of clotting due to coronary artery disease. Acetaminophen was prescribed as needed for pain. Nitroglycerine was prescribed sublingually as needed for chest pain and regularly for prevention of chest pain.

2. Contraindications: None documented

. Drug Interactions: No specific adverse drug-drug interactions are documented.

. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

. Prescriber: Not clearly identified.

. Review: The most recent annual physical examination was refused on 3/13/90 as in previous years. The most recent mental status examination is dated 8/23/88; the most recent social history is dated 9/20/85. The were medical consultations on 8/10/90, 8/23/90, and 11/8/90. There have been monthly physician progress notes recently. On 8/9/90 a cardiac catheterization was performed which confirmed the coronary artery disease. There was a normal electrocardiogram on 10/31/90. There is no documentation as to the allergy to all psychotropic agents in the chart. The progress notes do not document any psychotic symptoms beyond overtalkativeness and uncooperativeness. This case should be reviewed to assess whether it is necessary to be in the state hospital. He is on the behavior treatment unit but the nature of these behavior problems is not documented in the chart.

. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

0. Medication Record: Present.

ntegration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER: 3-36744
ADMISSION: 5/15/80
SITE: Montana State Hospital
BIRTHDATE: 3/20/53

DIAGNOSIS: Schizophrenia, paranoid
Status-post deep venous thrombosis 2/11/89

MEDICATIONS: Clozapine
HISTORY: Acetaminophen (Tylenol^{R})

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; not mention is made of past adverse drug reactio s

3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Clozapine is an antipsychotic agent used to treat some of the manifestations of schizophrenia. Acetaminophen was prescribed as needed for pain.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: There have been a couple of apparent reactions clozapine. On 9/25/90 confusion, ataxia, dusky color, slurred speech tachycardia and erratic blood pressure were report in a medical clinic consultation. It was felt that these symptoms could have been due to s seizure secondary to clozapine. On 10/22/90 a progress notes documents feeling overmedicated, oozy, time going backward. It is also noted on this date that there were no hallucination or delusions. The dosage of clozapine has been tapered up and down to try to reach an acceptable dosage.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 1/8/88. The most recen annual physical examination is dated 1/31/90; the most recent mental status examination is dated 2/13/90. The were medical consultations on 4/12/90, 9/25/90, and 11/5/90. There have been twice monthly physician progress notes recently. The new agent clozapine is thought to be the most effective drug yet tried, but side effects problems have intervened Time will tell if an effective and side effect-free dosage can be achieved.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER: 24634 DIAGNOSIS: Schizophrenia
ADMISSION: 11/18/88 Parkinsonism
SITE: Montana State Hospital Aggressive/belligerent behavior
BIRTHDATE: 1/19/15

MEDICATIONS: Ibuprofen (Motrin^{R})
Haloperidol (Haldol^{R})
Levodopa/carbidopa (Sinemet^{R})
Selenium sulfide shampoo (Selsun^{R})
Milk of magnesia
Bisacodyl suppositories
Bismuth subgallate, bismuth resorcin compound, benzoyl benzoate, zinc oxide, and balsam Peru suppositories (Anusol^{R})

HISTORY:

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Ibuprofen is an analgesic/antiinflammatory agent. It was discontinued for lack of an as needed indication on 11/14/90. Haloperidol is an antipsychotic agent used to suppress some of the manifestations of schizophrenia. Levodopa/carbidopa was used to treat idiopathic parkinsonism. Selenium sulfide shampoo is an antidandruff shampoo. Milk of magnesia and the suppositories were used as needed for constipation.

2. Contraindications: The coexistence of schizophrenia and idiopathic parkinsonism create a problem in that treatment of one may accentuate the other.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. There is no need to split the daily dosage of haloperidol.

6. Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 11/27/89. The were clinical conference notes on 8/11/89, 11/14/89, 2/13/90, 5/15/90, and 8/21/90. There have been quarterly physician progress notes recently. Pharmacist review has been documented monthly over the past year..

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER:	22617	DIAGNOSIS:	Status-post myocardial infarction, 9/86
ADMISSION:	1/21/87		Seizure disorder
CITE:	Montana State Hospital		Schizophrenia, chronic undifferentiated
IRTHDATE:	11/21/26		Heart Failure
		MEDICATIONS:	Milk of magnesia
			Emollient (Keri Lotion^{R})
			Magnesium and aluminum hydroxides (Maalox TC^{R})
			Acetaminophen (Tylenol^{R})
			Phenytoin (Dilantin^{R})
			Digoxin (Lanoxicaps^{R})
			Docusate calcium (Surfak^{R})
			Haloperidol (Haldol^{R})
			Phenobarbital
			Furosemide (Lasix^{R})

ISTORY:

1. Medication: Not documented.

. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

. Drug Abuse: Not documented.

CURRENT MEDICATIONS

. Indications: Milk of magnesia was prescribed as needed for constipation. Emollient was used as needed for dry skin. Magnesium and aluminum hydroxides suspension was prescribed as needed. It is not stated "for what?" but it is an antacid used for various stomach symptoms. Acetaminophen was prescribed as needed; "for what?" is not stated. None of these as needed medications have been sued in several months. Their continued need should be reassessed. Phenytoin and phenobarbital are anticonvulsants. There is a diagnosis of seizure disorder, but no details are given. There is no seizure record in the chart and no seizure recorded in the physicians progress notes. An electroencephalogram on 9/12/89 was normal with no epileptiform discharges. The continued need for both or either agent should be assessed. Digoxin increase the force of contraction of the heart; furosemide helps rid the body of excess fluid. These two agents are used in the management of heart failure. Docusate is a stool softener which is prescribed to help prevent constipation. Haloperidol is an antipsychotic agent used to suppress some of the manifestations of schizophrenia.

2. Contraindications: A seizure disorder is a relative contraindication to the use of any antipsychotic agent. There have been no seizure recorded and therefore this does not seem to be a problem in this case.

3. Drug Interactions: No specific adverse drug-drug interactions are documented. Phenytoin and phenobarbital affect the rates at which the other is eliminated; this must be taken into account whenever dosage changes of either agent takes place.

Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. Serum phenobarbital and phenytoin concentrations were within the usual therapeutic range on 10/17/90. The serum digoxin concentration has been low and the dosage increase to somewhat high levels in response. The most recent serum digoxin concentration on 11/28/90 was at the low end of the usual therapeutic range.

6. Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 1/17/90. There have been physician progress notes ranging from once every three months to twice a month during the last year. Pharmacist review is documented monthly. There appears to be a need to reassess the need for several medications in this individual(see indications).

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER: 52444
ADMISSION: 3/30/92
SITE: Montana State Hospital
IRTHDATE: 11/14/05

DIAGNOSIS: Abdominal aortic aneurysm
Mass in right lung
Dementia
Renal Insufficiency

MEDICATIONS: Lorazepam
Magnesium and aluminum hydroxides (Maalox TC^{R})
Acetaminophen (Tylenol^{R})
Clonazepam (Klonopin^{R})

HISTORY:

. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Not documented.

3. Drug Abuse: Not documented.

URRENT MEDICATIONS

1. Indications: Lorazepam is an antianxiety agent. Its specific use in this case is not documented. Magnesium and aluminum hydroxides is an antacid; Acetaminophen is an analgesic. These two agents were prescribed as needed; "for what?" was not documented. Clonazepam is most often used as an anticonvulsant. Its need here is not documented.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented. Clonazepam and lorazepam are in the same pharmacological class. Duplication can lead to excessive sedation and worsening of dementia.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits.

6. Prescriber: Clearly identified.

Review: The most recent annual physical examination is dated 4/10/90. There have been ten physician progress notes in the past eight months. There is a clinical conference note on 5/29/90. Pharmacist review is documented monthly. There has been a slow pulse of about 48 for a long time, probably secondary to an old myocardial infarction. Has this slow pulse and resulting decrease in cardiac output (he has a diagnosis of heart failure) been assessed as to its effect on the dementia symptoms? Has the combination of benzodiazepines contributed to the dementia?

Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

.0. Medication Record: Present.

Integration: Not specifically documented.

Comments: This individual has had a mass identified on chest x-ray (3/30/90) which appears larger on 9/26/90. It has been labelled as likely lung cancer. Two hospital physicians agreed that surgery was not appropriate and have elected not to treat this lesion. As far as I could tell from the ward recor the patient was not informed of this mass. Although I tend to agree with the decision of the hospital physicians, the patient should have a say in his treatment. It appears that the patient is competent enough to sign over his check to the hospital, therefore, he must be competent enough to elect his ow treatment of this mass.

MEDICATION CHECKLIST

UMBER: 28152
ADMISSION: 11/5/90
SITE: Montana State Hospital
IRTHDATE: [43 years old]

DIAGNOSIS: Chromic Schizophrenia
Chronic Obstructive Lung disease
History of seizures

MEDICATIONS: Phenobarbital
Phenytoin (Dilantin^{R})
Multiple vitamins
Emollient (Keri Lotion^{R})
Lorazepam (Ativan^{R})
Dandruff shamp
Fluphenazine decanoate (Prolixin^{R})
Trihexyphenidyl (Artane^{R})
Theophylline (SloBid^{R})
Metaproterenol (Alupent^{R})
Oxygen

ISTORY:

1. Medication: Not documented, except for those at MSH.

   Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

   Drug Abuse: Not documented.

URRENT MEDICATIONS

1. Indications: Phenobarbital and phenytoin are both anticonvulsant agents. There is a history of seizures. There is no documented indication for multiple vitamins or the dandruff shampoo. Emollient was used for dry skin. Lorazepam is an antianxiety agent; its use here is not specifically documented. Fluphenazine decanoate is a long acting, injectable antipsychotic agent used to suppress some of the manifestations of schizophrenia. Trihexyphenidyl is an anticholinergic agent which was used to prevent extrapyramidal side effects from the fluphenazine. Theophylline and metaproterenol are intended to help her breath easier in the presence of obstructive lung disease.

2. Contraindications: A seizure disorder is a relative contraindication to the use of any antipsychotic agent; there have been no seizure in this case.

3. Drug Interactions: No specific adverse drug-drug interactions are documented. Phenytoin and phenobarbital affect the elimination of each other; any change in the dosage of one agent must take into account the other agent.

4. Adverse Drug Reactions: None documented. There were elevated liver enzymes on 11/7/90. It is possible that these were secondary to medication, eg. anticonvulsants, but this was never investigated.

5. Dosage: All dosages are within acceptable limits. Serum concentration of theophylline have been low, but this agent was recently discontinued. Serum concentrations of phenytoin have been therapeutic, but the concentrations of phenobarbital have been somewhat low.

6. Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 11/5/90. There have been nine physician progress notes since 11/5/90 when she was admitted to this unit. The need for anticonvulsants should be assessed. There have been no seizures documented since at least 1984, and maybe not since one as a child in 1971(physical examination 8/30/90). Quite often after three years without seizures it is possible to withdraw anticonvulsants without a return of the seizure disorder. The abnormal liver enzymes of 11/7/90 should be evaluated. On 11/13/90, she had a pa of 57 torr on room air. The need for oxygen should be reassessed.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

Comments: On admission to this campus and this unit an order was written for "No Cigarettes". Although I support stopping smoking for anyone, this should be done in concert with the patient. Five days into this a progress note states "begging for cigarettes", illustrating the inhumanity of such an actio Consideration should be given to a more humane means of accomplishing to no smoking goal including nicotine gum.

MEDICATION CHECKLIST

UMBER: 24736
ADMISSION: 9/3/87
ITE: Montana State Hospital
IRTHDATE: 12/3/43

DIAGNOSIS: Huntington's chorea
Type II diabetes mellitus

MEDICATIONS: Sodium phosphate/biphosphate enema (Fleet's®)
Lactulose (Cholac®)
Psyllium (Metamucil®)
Docusate calcium (Surfak®)
Thiothixene
Phenytoin (Dilantin®)

ISTORY:

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Not documented.

URRENT MEDICATIONS

1. Indications: Lactulose is an osmotic laxative; psyllium is a bulk-forming laxative; docusate is a stool softener; sodium phosphate/biphosphate enema is an osmotic laxative prescribed as needed. Are all four agents needed for control of constipation? Thiothixene is an antipsychotic agent. It was originally started for aggressive behavior (11/13/90) and the dosage was recently decrease since there has been no aggressive behavior in several months. Phenytoin is an anticonvulsant which was prescribed for a questionable seizure (11/13/90); its need should be reassessed.

2. Contraindications: None documented

Drug Interactions: No specific adverse drug-drug interactions are documented.

Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. Serum phenytoin concentrations have been within the usual therapeutic range.

6. Prescriber: Clearly identified.

Review: The most recent annual physical examination is dated 10/30/90. There have been nine physician progress notes in 1990. There were clinical conference notes on 10/31/89, 1/30/90, 4/30/90, and 8/7/90. Pharmacist review is documented monthly. On 11/13/90, a physician progress note does address the need for thiothixene and phenytoin. Hopefully, efforts have begun to eliminate unneeded medication. The use of multiple laxative for constipation should also be addressed.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER: 40-22337
ADMISSION: 2/6/80
SITE: Montana State Hospital
IRTHDATE: 7/8/87

DIAGNOSIS:
Organic brain syndrome secondary to viral encephalitis
Hypertension
Seizure disorder
Behavior disorder, passive/aggressive

MEDICATIONS:
Phenytoin (Dilantin^{R})
Psyllium (Metamucil^{R})
Docusate calcium (Surfak^{R})
Sodium phosphate/biphosphate enema (Fleet's^{R})
Mesoridazine (Serentil^{R})
Primidone (Mysoline^{R})
Carbamazepine (Tegretol^{R})

HISTORY:

. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Not documented.

URRENT MEDICATIONS

1. Indications: Psyllium is a bulk-forming laxative; docusate is a stool softener; sodium phosphate/biphosphate enema is an osmotic laxative prescribed as needed. All are intended for the management of constipation. Phenytoin, primidone, and carbamazepine are all anticonvulsant agents. The first two are intended to prevent seizures. The latter was prescribed for behavior, but was discontinued 11/20/90 due to lack of efficacy. Mesoridazine is an antipsychotic agent. It appears to be used in this case to suppress passive/aggressive behavior.

2. Contraindications: All antipsychotics are relatively contraindicated in the presence of a seizure disorder. There is no indication of a problem in this case.

3. Drug Interactions: No specific adverse drug-drug interactions are documented. Each of the anticonvulsants interfere with the elimination rate of the other; any change in the dosage of one agent must take into account the other agents.

Adverse Drug Reactions: Ataxia is mention in the 4/23/90 progress note. This is not an uncommon side effect of anticonvulsants, but there is no further mention of this problem.

Dosage: All dosages are within acceptable limits. Serum concentrations of phenytoin and phenobarbital (an active metabolite of primidone) have been within the usual therapeutic range. The primidone concentration should also be measured regularly. The serum carbamazepine concentration never did get up into the usual therapeutic range.

Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 10/25/90. There have been ten physician progress notes in the last seven months. There are clinical conference notes on 11/7/89, 2/6/90, 5/8/90, and 8/14/90. Pharmacist review is documented monthly. There is no seizure record present despite a physician note on 11/20/90 that one should be started as soon as possible. This note also recommended that anticonvulsants be reviewed. There also appears to be an unresolved behavior problem. The need and role of mesoridazine should be reassessed.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER: 3-20063
ADMISSION: 5/30/84
SITE: Montana State Hospital
IRTHDATE: 4/21/15

DIAGNOSIS:
Status-post cataract surgery 1987
Paranoid schizophrenia
Labile hypertension
Tardive dyskinesia
Transient ischemic attack
Constipation

MEDICATIONS:
Benztropine
Docusate calcium
White petrolatum (Vaseline^{R})
Fluphenazine
Antacid
Milk of magnesia
Lorazepam (Ativan^{R})

HISTORY:

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions

3. Drug Abuse: Not documented.

URRENT MEDICATIONS

1. Indications: Docusate is a stool softener; Milk of magnesia is a laxative . Both were used in the management of constipation. There is no documented indication for the as needed antacid. White petrolatum was used for a dry nose. Fluphenazine is an antipsychotic agent which was used to suppress some of the manifestation of schizophrenia and to help control aggressive behavior. Benztropine is an anticholinergic agent. It was used to prevent or treat extrapyramidal side effects from the fluphenazine. It is usually not necessary to continue this agent long term. No symptoms have been described in the progress notes recently. Lorazepam is an antianxiety agent which was prescribed to help control aggression. The aggression occurred during an attempt to reduce the dosage of fluphenazine. The dosage of fluphenazine was also increase on this date (10/24/90).

Contraindications: Tardive dyskinesia is a relative contraindication to the use of traditional antipsychotics. The dosage of fluphenazine was tapered which resulted in aggressive behavior making it impossible to eliminate it. If the tongue thrusting gets to be a big problem, clozapine may be an alternative.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: The benztropine may be contributing to the problem with constipation. Dryness caused by benztropine could also contribute to the frequent nosebleeds. Tardive dyskinesia has resulted from long term antipsychotic usage.

Dosage: All dosages are within acceptable limits. There is no reason to split the daily dosage of fluphenazine.

6. Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 4/27/90. There is a social history update dated 6/1/89. The was an outside consultation regarding transient ischemic attacks on 10/5/89 by a neurologist who suggested aspirin on a regular basis. This has been discontinued. Reinstituting aspirin therapy should be reconsidered. There has been several medical clinic referrals for nosebleeds over the last few years. There have been monthly physician progress notes recently. The recent exacerbation resulting from an attempt to reduce the dosage of antipsychotic. This attempt was appropriate; unfortunately it did not work. Pharmacist review has been documented monthly..

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER:	4-49327	DIAGNOSIS:	Dementia
ADMISSION:	9/16/86		Organic Brain Syndrome
SITE:	Montana State Hospital		Huntington's chorea with intermittently aggressive behavior
BIRTHATE:	1/19/31		Constipation
		MEDICATIONS:	Diazepam
			Docusate sodium (Diocto^{R})
			Nutritional supplement (Sustacal^{R})
			Selenium sulfide shampoo (Selsun^{R})
			Trifluoperazine (Stelazine^{R})
			Bisacodyl
			Milk of magnesia

HISTORY:

1. Medication: Documented on the Medication History Form dated 9/16/86.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

3. Drug Abuse: Documented on the Medication History Form.

URRENT MEDICATIONS

1. Indications: Docusate is a stool softener; bisacodyl and milk of magnesia are laxatives, both prescribed as needed. These agents were used in the management of constipation. The nutritional supplement was started in response to a low serum albumin concentration which suggests inadequate nutrition. Trifluoperazine is an antipsychotic agent which was used to help control aggression. Diazepam is an antianxiety agent which was used for muscle tension.

Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: The progress note on 9/26/90 suggest that diazepam may have contributed to the disinhibited behavior. The dosage was decreased.

Dosage: All dosages are within acceptable limits.

Prescriber: Clearly identified.

Review: The most recent treatment plan is dated 10/29/90. The most recent annual physical examination is dated 4/20/89. The most recent social history is dated 7/14/89. The was an occupational therapy consultation regarding swallowing concerns on 1/31/90. There have been monthly physician progress notes recently. Pharmacist review has been documented monthly. The disinhibited behavior seems to have responded rather well to low dosages of trifluoperazine and diazepam.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER:	3-16940	DIAGNOSIS:	Schizophrenia
ADMISSION:	11/1/83		History of hypothyroidism
SITE:	Montana State Hospital		Parkinson's secondary to medication
BIRTHDATE:	?	MEDICATIONS:	Benztropine (Cogentin^{R})
			Trihexyphenidyl (Artane^{R})
			Diphenhydramine (Benadryl^{R})
			Haloperidol decanoate (Haldol^{R})
			Haloperidol (Haldol^{R})
			Fluphenazine decanoate (Prolixin^{R})
			Thiothixene (Navane^{R})
			Lithium citrate
			Chloral hydrate
			Nutritional supplement (Sustacal^{R})
			Docusate sodium (Diocto^{R})

HISTORY:

1. Medication: Documented on the Medication History Form which is not dated.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reaction.

3. Drug Abuse: Documented on the Medication History Form.

CURRENT MEDICATIONS

1. Indications: Haloperidol and fluphenazine are antipsychotic agents used to suppress some of the manifestations of schizophrenia. Haloperidol oral concentrate was originally used, but due to patient refusal to take the medication it was hidden in the nutritional supplement or injected IM. This was later changed to the longacting injectable decanoate salt due to the compliance problems. Due to continuing symptoms, the antipsychotic was changed to fluphenazine decanoate on 11/7/90. On 11/27/90, there appear to be little response to fluphenazine and the antipsychotic was changed to thiothixene oral concentrate. Lithium citrate syrup was apparently also used adjunctively in the management of schizophrenia. Benztropine and trihexyphenidyl are anticholinergic agent used to treat extrapyramidal side effects from the antipsychotic agents. Trihexyphenidyl was administered orally on a regular basis, while benztropine as prescribed as needed IM. Diphenhydramine, a H1-antihistamine was also used to control these side effects. Chloral hydrate was used to treat insomnia on a temporary basis. Docusate is a stool softener. The nutritional supplement was used apparently as a means of administering mediation.

2. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: Numerous notes document extrapyramidal side effects from the antipsychotic medication. Gastrointestinal side effects are also mentioned in the progress notes. These are common with lithium especially when administered in single daily dosages.

5. Dosage: All dosages are within acceptable limits.There is no need to split the daily dosages of the antipsychotic agents. Serum lithium concentrations have been within the usual therapeutic range. It is usually better to administer lithium in multiple dosages each day (two to four) in order to cut down on the gastrointestinal side effects..

8. Goals: Not specifically documented.

6. Prescriber: Clearly identified.

7. Review: The most recent treatment plan is dated 11/5/89, with an update on 9/21/90. The annual physical examination was refused 8/24/90; the most recent Psychiatric evaluation is dated 11/3/83; the most recent social history is dated 6/8/89. There were no outside consultations during 1990. There have been several physician progress notes each month recently. Pharmacist review is documented monthly. There have been numerous dosage and drug changes over the last several months in an effort to control her psychotic illness. None have been very successful. In addition, there have been continuing problems with extrapyramidal side effects. She may be a candidate for clozapine.

9. Patient Education: The patient refused to talk about medications on 9/19/90.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER:	4-37401	DIAGNOSIS:	Status-post frontal lobotomy 1949
ADMISSION:	9/13/89		Organic affective disorder
SITE:	Montana State Hospital		Tobacco dependence
BIRTHDATE:	2/16/18		Chronic obstructive airway disease
			Rheumatoid arthritis
			Seizure disorder
			Hypothyroidism
		MEDICATIONS:	Levothyroxine (Synthroid^{R})
			Milk of magnesia
			Docusate sodium (Colace^{R})
			Acetaminophen (Tylenol^{R})
			Haloperidol (Haldol^{R})
			Carbamazepine (Tegretol^{R})
			Lorazepam (Ativan^{R})
			Lithium
			Benztropine
			Salicylic acid ointment
			Salicylic acid plaster

ISTORY:

1. Medication: Documented on the Medication History Form which is not dated.

. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

. Drug Abuse: Not documented on the Medication History Form; tobacco abuse is documented as a diagnosis.

URRENT MEDICATIONS

1. Indications: Levothyroxine was used as replacement for hypothyroidism. Milk of magnesia is a laxative which was prescribed as needed. Docusate is a stool softener. Acetaminophen was prescribed as needed for pain. Salicylic acid ointment and plaster was used to treat a corn on the foot. Carbamazepine was used to control aggression. Even though there is a diagnosis of seizure disorder, the physical examination (9/27/89) states that there is not history of seizure and carbamazepine was for behavior. Haloperidol is an antipsychotic agent which was used to help control aggressive behavior. Because of continuing agitation and extrapyramidal side effects the dosage was tapered and haloperidol was discontinued on 9/27/90. On this date, lorazepam, an antianxiety agent, was started. Lithium was also used to help control behavior. Benztropine is an anticholinergic used to treat extrapyramidal side effects from haloperidol. It was discontinues a few days after haloperidol was stopped.

. Contraindications: None documented.

Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: There was a slight neutropenia, probably as a result of carbamazepine therapy, but this does not represent a threat to the patient. Extrapyramidal side effects from haloperidol are documented on 9/27/90.

5. Dosage: All dosages are within acceptable limits. Serum carbamazepine concentrations have been within the usual therapeutic range.

6. Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 9/27/89. Psychiatric evaluation is dated 9/18/89; the most recent social history is dated 9/15/89. There have been several physician progress notes each month recently. Pharmacist review has been documented monthly. It has been difficult to control the aggressive symptoms in recent months. The effective treatment has not yet been found. Lithium has recently been added and its effect has not yet been manifest.

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

UMBER: 2-51103 DIAGNOSIS: Paranoid schizophrenia
ADMISSION: 9/13/90
SITE: Montana State Hospital
IRTHDATE: 8/23/56

MEDICATIONS: Lithium
Fluoxetine (Prozac^{R})
Ethinyl estradiol and norethindrone (Ortho Novum 1/35)
Acetaminophen (Tylenol^{R})
Aspirin
Loxapine (Loxitane^{R})
Benztropine (Cogentin^{R})

ISTORY:

1. Medication: Documented on the Medication History Form dated 9/14/90.

. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reactions.

. Drug Abuse: Documented on the Medication History Form.

CURRENT MEDICATIONS

1. Indications: Lithium and fluoxetine were continued on admission. There were both discontinued about a month later once a diagnosis had been established. Loxapine is an antipsychotic agent used to suppress some of the manifestations of schizophrenia. Benztropine is an anticholinergic agent used to prevent extrapyramidal side effects from the loxapine. Acetaminophen and aspirin were both prescribed as needed for pain. Ethinyl estradiol and norethindrone was prescribed as a contraceptive.

. Contraindications: None documented.

3. Drug Interactions: No specific adverse drug-drug interactions are documented.

4. Adverse Drug Reactions: None documented.

Dosage: All dosages are within acceptable limits. There is no reason to split the daily dosage of loxapine.

Prescriber: Clearly identified.

7. Review: The treatment plan is not on the ward chart. The physical examination report is not in the ward chart. The most recent mental status examination is dated 11/3/90. There have been three physician progress notes since admission. A diagnosis has just been established and treatment started.

3. Goals: Not specifically documented.

Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

MEDICATION CHECKLIST

NUMBER: 4-15091 DIAGNOSIS: Schizophrenia
ADMISSION: 6/4/44
SITE: Montana State Hospital
BIRTHDATE: 8/27/14

MEDICATIONS:Lorazepam (Ativan^{R})
Haloperidol (Haldol^{R})
Trihexyphenidyl (Artane^{R})
Temazepam (Restoril^{R})
Nutritional supplement (Sustacal^{R})
Clotrimazole cream (Lotrimin^{R})
Acetaminophen (Tylenol^{R})
Ibuprofen (Motrin^{R})

HISTORY:

1. Medication: Not documented.

2. Allergy/Adverse Drug Reaction: Allergies are documented on the Medication Administration Record; no mention is made of past adverse drug reaction.

3. Drug Abuse: Not documented.

CURRENT MEDICATIONS

1. Indications: Haloperidol is an antipsychotic agent. It is useful for the suppression of some of the manifestations of schizophrenia, but also appears to be used to suppress aggressive outbursts. Lorazepam is an antianxiety agent which appears to also be directed at aggressive outbursts. Trihexyphenidyl is an anticholinergic agent which was used to treat or prevent extrapyramidal side effects from the haloperidol. It is usually not necessary to continue the anticholinergic indefinitely. Since there are no side effects described in the progress, this agent should be tapered and discontinued. Temazepam is an hypnotic agent which was prescribed as needed for insomnia. Nutritional supplement was prescribed as needed when she does not eat. Clotrimazole is an antifungal cream which was applied to a rash in the groin area. Ibuprofen is an analgesic/antiinflammatory agent used as need for pain associated with a fractured finger. Acetaminophen was prescribed as needed for pain.

2. Contraindications: None documented

3. Drug Interactions: No specific adverse drug-drug interactions are documented. Lorazepam and temazepam are in the same pharmacological class. When used together the effect can accumulate and create problems. In the elderly, this situation is commonly identified as contributing to dementia symptoms.

4. Adverse Drug Reactions: None documented.

5. Dosage: All dosages are within acceptable limits. Temazepam is a slow onset agent, and therefore, is not ideal for an as needed sleeper. A more rapid acting drug would be preferred.

6. Prescriber: Clearly identified.

7. Review: The most recent annual physical examination is dated 1/13/87. the most recent social history is dated 12/16/86. There were several medical clinic referrals in 1990. There have been bimonthly physician progress notes recently. A note on 9/4/90 states there have been no aggressive outburst since 7/15/90. It may be time to try to reduce the dosage or eliminate one of the psychotropic agents..

8. Goals: Not specifically documented.

9. Patient Education: Not specifically documented.

10. Medication Record: Present.

Integration: Not specifically documented.

APPENDIX C

CONSULTANT ROSTER

CONSULTANTS AND BOARD MEMBERS

CONSULTANT ROSTER

(Individual resumes are available upon request)

Philip Bornstein, Ph.D., Clinical Psychologist, Missoula, MT

William Doctor, Pharm.D., Clinical Pharmacist, Missoula, MT

Sharon Harris, M.S.,RN, Psychiatric Nurse, Billings, MT

Paul Meyer, MA, Missoula, MT

Michael Rivey, MS, Pharmacist, Missoula, MT

Frank Seitz, Ph.D., Clinical Psychologist, Bozeman, MT

Thomas Stage, M.D., Psychiatrist, Vienna, VA

BOARD MEMBERS

Wallace King, Board Chairman, Helena, MT

Arlene Breum, Vice Chair, Missouala, MT

Bob Visscher, Livingston, MT

STAFF

Kelly Moorse, Executive Director, Helena, MT

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DEPARTMENT OF INSTITUTIONS
MONTANA STATE HOSPITAL

STAN STEPHENS, GOVERNOR

WARM SPRINGS, MONTANA 59756-0300

STATE OF MONTANA

(406) 693-7000

June 10, 1991

Wallace King, Chairman
Mental Disabilities Board of Visitors
Capitol Station
Helena, Montana 59620

Dear Mr. King:

Attached is our response to the Mental Disabilities Board of Visitors Report, Fiscal Year 1991, on Montana State Hospital.

Because of the need to submit this response to the Department of Institutions prior to submitting it to the Mental Disabilities Board of Visitors, your receipt of this response may be slightly late. By copy of this letter, I am requesting that Dan Anderson, Administrator, Mental Health Division, Department of Institutions, return this report to your office immediately upon review.

Thank you for affording us with the opportunity of responding to your report. I would be most willing to meet with you and/or other members of the Mental Disabilities Board of Visitors concerning our response.

Very sincerely,

Jane Edwards

Jane Edwards
Superintendent
Montana State Hospital

JE/sp
Enclosure

cc: Dan Anderson

"AN EQUAL OPPORTUNITY EMPLOYER"

JUL 11 1991

RESPONSE TO THE MENTAL DISABILITIES BOARD OF VISITORS REPORT

FISCAL YEAR 1991

MONTANA STATE HOSPITAL

MISSION OF THE STATE HOSPITAL

We agree that the mission of the State Hospital needs to be refined. A Program Development Committee was established in January of 1991 on the Warm Springs Campus of Montana State Hospital for the overall purpose of proposing a clear mission of the hospital and its treatment components and recommending organizational changes within the treatment program, staff deployment, and treatment strategies. Ed Amberg has been appointed as Program Development Coordinator to work with this committee in a leadership role to ensure that committee activities are goal directed and focused, to provide technical assistance and research expertise, and to facilitate timely response and action to committee recommendations. The following issues are under review by the committee who will make recommendations for policy, procedure, staffing and organizational changes consistent with JCAHO standards.

A. Propose a clear statement of the mission of Montana State Hospital to include a description of the specific types of patients who are appropriate for evaluation and treatment at Montana State Hospital and the services required to best meet the needs of those patients

B. Make recommendations for the appropriate organization of the hospital's total treatment program to best carry out the mission of Montana State Hospital including, but not limited to, administrative structure, treatment unit structure, professional staff deployment

C. Establish well articulated missions for each treatment unit including appropriate patients to be served, goals of the treatment programs, recommended treatment modalities to best meet unit goals

D. Describe the types of patients who are currently in Montana State Hospital who fall outside the stated mission and recommend ways the hospital can best deal with those patients

E. Recommend admission/discharge procedures which will assist in preventing admission of inappropropriate patients and facilitate rapid discharge of inappropriate patients

F. Make recommendations to address specific treatment issues such as:

    1. Medication education services on each treatment unit

2. Reduction in the number of civil patients in the Xanthopoulos Treatment Facility, including changes necessary to ensure that other units successfully manage difficult patients
3. Monitoring of restraint and seclusion use
4. Informed consent
5. Involuntary administration of medications
6. Patient basic education and pre-vocational training programs
7. Resident employment
8. Utilization review and medical audit process
9. Treatment plan development and implementation
10. Documentation issues

G. Identify management information data needed by treatment professionals within each of the treatment units

H. Recommend procedures which can be implemented for outcome measurement

Through the Program Development Committee, a concerted effort is in progress to examine, redefine, and improve the operation of and treatment services provided by Montana State Hospital.

RECOMMENDATIONS:

1. The Program Development Committee is reviewing the role of Montana State Hospital and will propose a mission statement which addresses the hospital's purpose and the population to be served. As the process evolves, input will be sought through the Department of Institutions from community mental health centers, consumers, advocates, mental health advisory committees, and other mental health professionals. Additionally, a legislative committee will review these issues during the next biennium.

2. The Program Development Committee has been actively working on these issues since January, 1991.

3. The Program Development Committee has been actively working on these issues since January, 1991.

   The Mental Disabilities Board of Visitors' report states "All of the changes appears to be occurring in isolation and independent of the other units." Changes in the unit operation are made following discussions with and input from hospital staff, unit supervisors, staff psychiatrists and hospital mangement. Treatment strategies are developed to best meet the needs of those patients admitted to Montana State Hospital. The Hospital will continue to strengthen the degree to which each unit functions as a component in fulfilling the overall mission of the Hospital.

4. Education of organizations, agencies, and persons involved in the delivery of mental health services throughout the State of Montana is critical. Montana State Hospital and the Department

of Institutions hope that the Mental Disabilities Board of Visitors will actively participate in this educational process.

5. Hospital staff members strongly support accreditation efforts. The Program Development Committee is reviewing JCAHO standards and attempting to ensure that hospital services are in compliance with these standards to the greatest extent possible. Accreditation is a goal of the Hospital and the Department.

ADMISSIONS, PLACEMENTS AND DISCHARGES

RECOMMENDATIONS:

6. It is agreed that admission criteria to Montana State Hospital should be re-examined and revised; however, this can be accomplished only within the larger context of the entire mental health system. Part of the solution may be legislative changes in the commitment law.

   Hospital staff are working to make program changes that will enable patients to receive treatment and rehabilitation services that will assist them in making a successful return to their community in the shortest possible time. We hope to work more closely with community agencies in this effort. We plan to more actively involve community mental health service providers in aftercare and treatment planning beginning at the time of a person's admission to the hospital.

   The hospital attempts to discharge inappropriate admissions; however, other agencies (in example, district courts) will have to work with us in this area.

   The Department will contact the Developmental Disabilities Division regarding holding beds for clients experiencing a brief psychiatric hospitalization.

7. It is agreed that a stronger screening process for voluntary admissions is necessary. HB 862 attempted to strengthen the process but did not pass the legislature. The Department will revise the administrative rules under the current law to make screening more meaningful.

   The Medical Director has been asked to review all long term voluntary patients and to assure that all of them are either receiving needed active treatment or are moving toward a well-planned discharge.

8. The Program Development Committee is working on procedures that will enable discharge planning to begin at the time of a patient's admission to the hospital. We hope to actively involve community service providers in this planning process.

   Earlier and more frequent collaboration between hospital staff, community mental health centers and other support groups must occur in order to more effectively address discharge and aftercare issues.

9. The hospital will work with the Department of Institutions in providing additional admission information through the management information system. The Program Development Committee will be recommending a procedure which calls for a case utilization review and a review of treatment recommendations on all voluntary admissions.

CONSUMER ISSUES:

RECOMMENDATIONS:

10. The Program Development Committee expects to address these issues. Assistance in these efforts from the Mental Disabilities Board of Visitors and other advocacy groups would be appreciated.

    A consumer group has been established on the Extended Treatment Unit. The patients have developed a process by which they discuss issues and provide input to all patients and staff. This group has proven to be beneficial and effective and will serve as an example in assisting other units in this endeavor.

    The CSP Consumer and Family Support Coordinator will be contacted to offer Hospital staff assistance in working with the existing consumer group and/or starting other group(s).

11. Programs of this type have existed on some of the hospital's treatment units for some time. We are currently working through the Staff Development Department and the Program Development Coordinator to develop a standard curriculum for such a program that will be used on all hospital units. Some excellent instructional materials have already been obtained. Further, in April of 1991, a monthly patient/staff educational forum was established for the purpose of discussing various aspects of mental illness. These forums have been well accepted and attended by both patients and hospital staff.

12. The Hospital suggests that a committee consisting of a Hospital professional, a Mental Health Division staff person and a Board of Visitors staff person draft a proposed policy for consideration.

13. The Program Development Committee is currently working on this issue. A draft policy will be available for review by the Board before September 1, 1991.

14. The Program Development Committee is seeking input from staff and patients for a more positive term to describe the patient privilege of moving freely about the hospital grounds. The term "ground parole" will be discontinued by September 1, 1991.

15. Funds have been authorized for the purchase of furniture for the treatment units during the next biennium.

16. The hospital recognizes the problem of extensive smoking that occurs in patient living areas and the problems posed by second-hand smoke. We lack funds to retrofit buildings to deal with this problem more effectively; however, we are attempting to isolate smoking to only those areas that are appropriately ventilated. We are very aware of the problem and are open to suggestions for solutions. A new law on smoking in state buildings has been adopted. The Medical Director has been asked to develop a proposed policy for all areas of the Hospital.

TREATMENT APPROACHES/TREATMENT PLANS

SHORT TERM UNIT:

The Hospital agrees that serving a large number of patients with personality disorders in the State Hospital is not appropriate. The C-Ward Program is, however, a responsible response to the fact that a large number of people with personality disorders are referred to the State Hospital. Again, a system-wide approach is needed. The Department and the Hospital will work to define and stimulate the development of the necessary alternative services for people with serious personality disorders.

EXTENDED TREATMENT UNIT:

Many changes have been made in the quality and quantity of treatment programs offered on the Extended Treatment Unit; in example: medication education, mental illness awareness, relationships, self esteem issues, problem solving, and community preparedness are being addressed in scheduled group sessions.

Ongoing efforts through daily staff meetings, sharing of educational materials and new ideas, and individual counseling are being made to assist staff members in developing appropriate ways of interacting with patients with severe and persistent mental illness.

A review of staff allocation throughout the hospital has been undertaken with primary emphasis on providing additional professional staff to the Extended Treatment Unit. The positions of staff psychiatrist and occupational therapist should be filled within the next two to three months. Further, advertising for a psychologist and chemical dependency counselor will commence shortly.

XANTHOPOULOS TREATMENT FACILITY:

Within the past several months, major organizational changes have occurred in the Xanthopoulos Treatment Facility which have impacted the treatment programs offered to the patients on that unit and have addressed problems resulting from the heterogeneous mix on the various wards. The second floor of the facility houses the Psychiatric Intensive Care Unit which is designed for psychiatric treatment of patients who are voluntarily admitted or civilly committed to the hospital and are too aggressive or potentially too aggressive to themselves or others to be safely maintained on the general psychiatric units of Montana State Hospital. Both wards of

this unit are coed and patients residing in this unit are involved in a variety of psychiatric treatment programs which address their individual needs. The first floor of the Xanthopoulos Treatment Facility is designated as the Forensic Treatment Unit and is designed primarily for patients committed to Montana State Hospital under criminal statutes or from Montana State Prison. A small number of appropriately referred civilly committed patients are admitted to this unit when they have exhibited behaviors that are too dangerous to themself or others to allow residence on a less restrictive unit. With the exception of those persons committed for court ordered evaluation, patients on the forensic treatment unit are involved in a variety of psychiatric treatment programs which address their individual needs. The Xanthopoulos Treatment Facility provides a very comprehensive treatment program and there is opportunity on each unit for patients to progress to less restrictive treatment environments.

The hospital is also concerned about the continued placement of some patients who are elderly or who have severe organic brain injuries on the Xanthopoulos Treatment Facility. We believe, however, that these patients are receiving excellent and appropriate care consistent with their behavioral needs and physical infirmities. We continually seek other alternatives for their care and treatment but at this time very few options exist.

LONG TERM CARE UNIT:

It is suggested that the "behavior/mental status" section of the flow sheets be revised to include positive behaviors. Problems listed on the flow sheets are those problems which have brought the patient into the hospital and those problems which continue to make placement outside the hospital impossible. These problems are addressed on individual treatment plans. By recording on a daily basis the frequency of occurrence, the treatment team has a baseline to determine if goals are being met and approaches are effective. This data is used to revise the treatment plan on at least a quarterly basis. The treatment team discussed this suggestion when it was brought up during the site review. It was decided at that time to continue with the current system which provides information needed to work with the patient on current behavior problems.

GALEN CAMPUS:

House Bill 966 established a committee to study the past, current, and potential future uses of Montana State Hospital, both Galen and Warm Springs Campuses. The committee is to report the study's findings to the Fifty-Third Legislature. Committee membership will include consumers, health care professionals and legislators.

The problem of inconsistent detailing in physician orders concerning restraint/seclusion has been addressed. This issue requires frequent monitoring and reminders.

RECOMMENDATIONS:

17. This issue is being actively addressed by the Program Development Committee.

18. A completely revised treatment plan form is being tested at the present time. Changes needed in the treatment planning process that will correlate with the revised form are also being considered. We hope to more actively involve patients in the development of their treatment plan, focus on treatment objectives rather than problems, and institute some means of assessing the outcome of treatment services received by patients.

19. Problems noted in hospital treatment plans and in the charting of a patient's progress will, hopefully, be addressed through implementation of the new treatment plan form and revised documentation processes. Location of the treatment plan is presently under review by the Program Development Committee.

20. These issues are under review by the Program Development Committee and will be addressed in revised documentation policies and procedures.

21. Narcotics Anonymous and Alcoholics Anonymous programs have been established on the Warm Springs Campus. The hospital's request for two (2) chemical dependency counselor positions on the Warm Springs Campus in the next biennium was deleted from the hospital budget in the recent legislative session; however, the hospital plans to change two (2) currently authorized positions to chemical dependency counselor positions and hopes to fill these positions shortly.

22. The quality of staff interactions with patients is a subject of ongoing concern to supervisory and administrative personnel at the hospital. We are actively working to correct this problem through improved supervision, counseling, staff training, and the implementation of new treatment programs. Staffing for the Extended Treatment Unit is addressed in the remarks made earlier specific to the Extended Treatment Unit.

23. The phrase ".....and it will not get him anywhere" has been deleted from the approach on the care plan. However, it baffles the Administrator of the Mental Health Division to understand why this phrase is considered "punitive."

24. The revised treatment plan that is currently being tested contains a section for therapeutic effectiveness of work.

25. Diet sheets currently in use describe the terms "good", "fair" and "poor" in percentages of food eaten. This same description will be added to the graphic sheet where appetite is recorded.

New activity calendars have been purchased and installed. The calendars are larger and more legible. The calendars have also been lowered for easier access by patients confined to wheelchairs.

26. As addressed earlier in responses specific to the Xanthopoulos Treatment Facility, organizational changes have been implemented to integrate men and women on the two wards of the Psychiatric Intensive Care Unit, Xanthopoulos Treatment Facility. The changes are presently working well although some of these patients are very disturbed and are difficult to manage and treat in any setting.

27. The hospital has implemented a hospital policy to review the transfer of voluntary and civil involuntary committed patients to the Xanthopoulos Treatment Facility. Further, a policy is under consideration that will require review every thirty days of the continued placement of these patients on the Xanthopoulos Treatment Facility. In addition, the structure and role of all hospital treatment units is under review.

28. As noted above, a policy requiring the review of patient transfers to the Xanthopoulos Treatment Facility has been implemented. This policy requires documentation of alternative interventions and treatment approaches on other units that were used and failed. The policy also addresses regular administrative reviews by the Director of Treatment/Residential Services and the Medical Director. A policy requiring periodic review of the continued stay on the Xanthopoulos Treatment Facility is under consideration.

    It is the policy of the Montana State Hospital to house civil involuntary and voluntary patients on the Xanthopoulos Treatment Facility only under extraordinary circumstances when the patient's condition and behavior requires that level of security and type of structured treatment program. The placement of civil involuntary patients on the Xanthopoulos Treatment Facility is for the purpose of treating the specific behavior problem which resulted in the patient's transfer to the Xanthopoulos Treatment Facility. Periodic reviews of the placement of civil involuntary and voluntary patients on the Xanthopoulos Treatment Facility will be conducted to ensure that patients do not unnecessarily remain on the Xanthopoulos Treatment Facility.

29. This recommendation is addressed in responses to recommendations 27 and 28.

30. The approaches utilized in managing this patient's excessive fluid intake are the most effective interventions of all those tried. Even with 1:1 staffing, it has not been possible to continually monitor his water intake. He is known to make numerous visits to the bathroom where he drinks from the sink and shower. He has been placed in seclusion for documented weight gains of eight (8) pounds or more between the hours of 10:00 A.M. and 7:00 P.M. and for altered electrolytes which can

lead to seizures and more serious consequences. His activities have been increased to include arts and crafts five days per week; living skills two days per week; daily yard activities and social activities on the ward.

With the organization and programatic changes on the Xanthopoulos Treatment Facility, the water intoxication wing has been eliminated.

31. This patient requests placement on the Secure Care ward when he feels actively suicidal. When staff has not responded to those requests, he has made suicidal attempts. He does "eat and sleep" while on Secure Care but also participates minimally in treatment activities. He currently resides on the Forensic Rehabilitation ward where he marginally participates in the treatment program which includes group therapy with a licensed psychologist.

32. This patient was treated with antidepressants and tranquilizers due to depression, severe mood swings, suicidal ideation and panic attacks. This medication regime was felt to be appropriate and was not contraindicated by his drug abuse history. He was discharged in January, 1991.

33. The established diagnosis for this patient during this admission was Adjustment Disorder with Mixed Emotional Features, Antisocial Personality Disorder, Alcohol Abuse, Mixed Substance Abuse. The diagnosis of Paranoid Schizophrenia is not documented in the medical record. This patient's hospitalization included treatment in the Chemical Dependency Program on the Galen Campus which is consistent with his diagnosis. He was discharged in April, 1991.

SECLUSION/RESTRAINT

The Mental Disabilities Board of Visitors suggests that there be increased opportunities for hospital staff to receive MANDT training. During the month of June, 1991, the hospital will provide training so that ten (10) additional staff members can become certified MANDT trainers. This will provide the hospital with a total of fifteen (15) certified MANDT trainers. With the additional trainers, the hospital will have an increased ability to provide ongoing training and review programs. It should also be noted that this MANDT training program is being made available to other appropriate persons throughout the State of Montana.

RECOMMENDATIONS:

34. The hospital's seclusion and restraint policy is presently under review. Included in the review will be the current practice of housing civil patients in the secure care area of the Xanthopoulos Treatment Facility.

35. Patients in restraint are being regularly monitored every fifteen minutes; documentation in the nurses notes verifies this action. Random review of hospital-wide restraint/seclusion practices will provide improved monitoring to ensure that staff members follow hospital policy concerning the use of restraint/seclusion.

36. The hospital will increase its efforts to ensure that staff members follow hospital policy regarding seclusion and restraint. Physician's orders for the specific patient noted in this recommendation have been rewritten to fully comply with policy requirements.

37. In April of 1991, a new daily reporting form for the use of restraint/seclusion was implemented. These reports are reviewed daily by hospital administration. Information from these daily reports is entered into a computer. Computer-generated reports are provided at regular intervals and are reviewed by hospital administration as well as the hospital's Restraint/Seclusion Committee. The hospital's Restraint/Seclusion Committee is also reassessing the criteria used for its review of restraint/seclusion interventions.

38. Critique of restraint and seclusion episodes after the event by hospital staff involved in the intervention is occurring throughout the hospital at the present time; however, this issue will be further addressed in hospital policy as well as in staff continuing education programs.

39. The hospital's restraint/seclusion policy is under review by hospital administration and the Program Development Committee. Guidelines for the release of patients from restraint/seclusion and more specific documentation which justifies continued use of restraint and seclusion will be addressed in hospital policy and staff continuing education programs. We would like to know in what part(s) of the Hospital this finding regarding observation notes was made.

40. The hospital will intensify its ongoing training programs for all treatment unit staff including certified mental health professionals and other licensed staff concerning restraint and seclusion, particularly initial justification and continuing justification for use of these interventions. Again, please let us know where this problem was observed.

41. The hospital will intensify its training of all treatment staff regarding restraint/seclusion and alternative interventions.

STAFF/STAFFING ISSUES

Funding for the purchase of three (3) computers during the next biennium has been approved.

RECOMMENDATIONS:

42. The hospital agrees that staffing of psychiatrists is inadequate. Recruitment for psychiatrists is ongoing. We have a signed commitment from one psychiatrist who will begin employment as soon as licensure in the State of Montana can be obtained.

43. This issue was addressed earlier in this response. Since these positions were deleted from the hospital's authorized positions in the next biennium, the hospital intends to change two (2) vacant positions to chemical dependency counselor positions. Upon approval of this change, these positions will be immediately advertised and filled.

44. An evaluation of nursing services at Montana State Hospital is currently in process by hospital administration and the Program Development Committee. It is our intention that this review will result in changes in staff assignments to better utilize existing registered nurses in the supervision of nursing staff and the provision of nursing care and treatment. Recruitment efforts are ongoing; two (2) registered nurses have been hired since the Mental Disabilities Board of Visitors site review.

    Additional registered nurse positions requested by the hospital in the most recent executive planning process were not considered during the budgeting process for the next biennium; therefore, it is critical that all authorized positions are filled and that registered nurses are appropriately utilized.

45. This issue has been discussed previously in this response. See "Extended Treatment Unit" discussion.

46. Admission physical examinations will be performed by the primary care physician assigned to the medical clinic on the Warm Springs Campus. Use of physicians assistants at Montana State Hospital will be given consideration if the hospital is unable to fill vacant primary care physician positions.

47. The Hospital and the Department agree that staff training is essential. We have not, however, been able to increase funding for this program.

48. The Program Development Committee composed of all levels of staff has been working since January, 1991, on these and other issues.

49. Hospital administration and the Program Development Committee are addressing this issue through changes in the allocation of staff to the treatment units. Further, as additional rehabilitation staff are hired, assignments will include the provision of evening and weekend activities.

With the new computer system, the pharmacy plans on expanding the medication review process at Montana State Hospital. Currently, plans are to review all long term patients. This will be done on a cyclic basis or through the utilization review process.

Although little evidence exists in the literature on the increased effectiveness of two neuroleptic agents used concurrently, this therapy is used most effectively in selected patients at the hospital. Attempts to stop one medication while increasing the single agent have been made and, in several cases, it has been necessary to restart dual agent therapy in order to maximize the effectiveness of drug therapy.

RECOMMENDATIONS:

50. The hospital is in the process of implementing the Abnormal Involuntary Movement Scale to evaluate patients for tardive dyskinesia. Training of appropriate staff in the use of the AIMS examination will be conducted on June 13, 1991, following which assessment of all patients will be initiated according to a recently developed hospital policy.

51. Programs of this type have existed on some of the hospital's treatment units for some time. We are currently working through the Staff Development Department and the Program Development Coordinator to develop a standard curriculum for such a program that will be used on all hospital units.

52. The hospital is currently reviewing the present record-keeping system; that review will include revision of the medical history form to include a history of all psychotropic medication usage. At the present time, the pharmacy can provide a history of drug usage during hospitalizations at Montana State Hospital.

53. This issue is addressed in the response to recommendation 50.

    Continued use of anticholinergic agents in some patients is necessary where attempts to taper or discontinue the medications have failed. When patients have problems with medication compliance, exposing them repeatedly to the discomforts of extrapyramidal symptoms is clinically contraindicated. These discomforts can only add to the complications of drug therapy.

54. The Department of Institutions and the Program Development Committee are currently working on the informed consent and guardianship issues. Assistance in this regard will be sought from the Mental Disabilities Board of Visitors.

    House Bills 635 and 968 relating to ethical decisions were recently signed by the Governor. The Department of Institutions and hospital administration will develop policies consistent with this legislation to direct hospital staff concerning these issues.

55. This patient has for years presented difficult treatment challenges. His serious mental illness has been complicated by life-long alcohol abuse. The problem of tardive dyskinesia was addressed at length in this patient. Neuroleptics had previously been the only treatment of any success. Navane was discontinued on January 30, 1991, and Clozaril, which has not been associated with tardive dyskinesia, was started on January 31, 1991. The patient was also seen by a neurologist who agreed with the diagnosis of tardive dyskinesia and with the hospital's course of treatment. The patient was discharged on May 8, 1991.

56. Improvement in this area is a high priority of the Medical Director. Efforts to improve documentation have started and will continue.

57. The hospital agrees that single dose administration of medication is preferrable; however, we have found that some patients do better with split dosing. In those cases where the desired effect is not attained with single administration, multiple administrations will be ordered.

SPECIFIC MEDICAL/MEDICATION ISSUES:

46745 — It was not discovered that this patient was pregnant until she was well into the second trimester of the pregnancy. She was seen by a consulting OB/Gyn specialist and our staff psychiatrists. It was determined at that time that the current medication regimen should be continued. It should be noted that current literature states the increased risk of congenital malformations is in infants of mothers who received this medication during the first trimester of pregnancy.

49208 — The dosage of beta-blocker being used in this patient is not for behavior control but rather for neuroleptic induced akathesia. Doses of ten to twenty milligrams three times daily have been very effective in reducing this side effect of neuroleptic drugs.

53313 — A concerted effort has been made to maintain this patient on the least amount of neuroleptics to contain her angry, paranoid psychosis. With appropriate adjustment of anticholinergic medication, the EPS described is not a continuing problem.

50531 — No evidence of EPS or tardive dyskinesia was apparent once patient stabilized on medication. This patient has a virulent illness which has necessitated repeated hospitalizations during 1990. She eventually reconstituted with Haldol and Lithium and was able to receive treatment in a less restrictive environment. Without neuroleptics, this would have been unlikely. Supervised compliance with Haldol resulted in patient's recovery and Clozaril was not needed.

651 This patient remains extremely psychotic and refuses medications which might help to stabilize her condition such as Tegretol, Lithium, or Clozaril. She does have a history of substance abuse, but has continued to derive benefit from a fixed dose of Ativan with no development of tolerance. This agent is used for chronic com-plaints of insomnia. Less potent agents as well as sleep hygiene remedies have been tried without success. The patient's psychiatric symptomatology significantly worsens when her sleep is disturbed.

742 There is clinical justification for the use of Prozac and Trazodone. Prozac is an activating antidepressant and this patient experienced insomnia related to Prozac which responded to Trazodone. In this treatment rationale, both agents are necessary for maximum antidepressant effects, yet their side effect profiles are prescribed in such a way as to complement one another. Haldol was used to curtail the patient's impulsivity, rejection sensitivity, and cognitive distortion. There is a recognized use for neuroleptics in this unstablized, borderline population.

580 This patient's medication regimen is being reviewed.

733 This patient's medication regimen is being reviewed.

176 The diagnosis of adjustment disorder with mixed emotional features is characterized by anxiety and depression which, in this case, responded to the use of antidepressants and antianxiety medication. Antipsychotic medications were used because of the patient's hallucinations caused by his psychoactive substance abuse. This patient's hospitalization included treatment in the chemical dependency program on the Galen Campus which is consistent with his diagnosis.

280 This patient's medication regimen is being reviewed.

744 This patient's medication regimen is being reviewed.

617 The medication regimen for this patient has been reviewed on many occasions with consultation from the pharmacist. Medications have been adjusted or discontinued as deemed appropriate by the attending physician.

444 It is the opinion of the attending physician that this patient's mental status does not allow him to comprehend the nature of his illness nor to participate in treatment decisions.

28152 This patient was being treated in the medical unit on the Galen Campus because of a serious chronic lung disease which was directly attributed to cigarette smoking. It is essential that the patient desire to quit smoking and receive extensive group therapy to gain any success with nicotine gum. Both of these objectives would be difficult at best with this patient who is very fragile and maintained on current medications at a borderline functional level. The patient's serious, intractable mental illness does not allow her to make the connection between her smoking and her lung disease and she would never willingly participate in a reduction or cessation of her smoking. Due to high doses of both neuroleptic agents and theophyline products, both of which may reduce or cause seizure activity, change in the anticonvulsant agents is not recommended.

24736 Phenytoin was discontinued February 2, 1991.

22337 The medication regimen for this patient is being reviewed.

15091 Although there are several Benzodiazepines with a more rapid onset then Temazepam, the hospital's Pharmacy and Therapeutics Committee has determined this to be the formulary product at Montana State Hospital. Several facets of hypnotic therapy were considered when making this decision. Restoril has given reliable results without causing undue daytime sedation. The drug's half-life is long enough (ten hours) to maintain sleep throughout the night. Finally, it has not been implicated in having the amnesic effect as some of the shorter acting agents, especially in older patients.

37401 Throughout the chart, it is mentioned that this patient suffered a reaction to toxic Lithium levels many years ago. She is again on Lithium which helps curb her violent outbursts. The levels are meticulously followed.

49327 Goals for this patient are specifically outlined in the treatment plan.

There are movements suggestive of mild tardive dyskinesia but efforts to decrease Prolixin resulted in increased confusion due to delusional thinking and a return of aggressive behavior. This patient refuses any neuroleptic except Prolixin. This patient has a long history of being very suspicious about his medications. Adjustments in the past have met with his total refusal to take medications. His current medication schedule has been discussed with him on many occasions and he requests divided doses of this medication and actually does better when it is given

more than once a day. This patient had been on prophylactic aspirin therapy but frequent nosebleeds resulted in its discontinuation.

16940 This patient is extremely suspicious about her medications and will only comply with certain types and doses. No current GI distress is noted. The patient does well on Navane when compliant. She is presently compliant and, therefore, is not felt to be a Clozaril candidate at this time.

This response is generated as a result of input from professional staff at Montana State Hospital. We would be most willing to discuss any portion of this response with the members and/or staff of the Mental Disabilities Board of Visitors.

Respectfully submitted,

Jane Edwards
Superintendent
Montana State Hospital

June 7, 1991

Dan Anderson
Administrator
Mental Health Division

July 1, 1991

27. The hospital has implemented a hospital policy to review the transfer of voluntary and civil involuntary committed patients to the Xanthopoulos Treatment Facility. Further, a policy is under consideration that will require review every thirty days of the continued placement of these patients on the Xanthopoulos Treatment Facility. In addition, the structure and role of all hospital treatment units is under review.

28. As noted above, a policy requiring the review of patient transfers to the Xanthopoulos Treatment Facility has been implemented. This policy requires documentation of alternative interventions and treatment approaches on other units that were used and failed. The policy also addresses regular administrative reviews by the Director of Treatment/Residential Services and the Medical Director. A policy requiring periodic review of the continued stay on the Xanthopoulos Treatment Facility is under consideration.

It is the policy of the Montana State Hospital to house civil involuntary and voluntary patients on the Xanthopoulos Treatment Facility only under extraordinary circumstances when the patient's condition and behavior requires that level of security and type of structured treatment program. The placement of civil involuntary patients on the Xanthopoulos Treatment Facility is for the purpose of treating the specific behavior problem which resulted in the patient's transfer to the Xanthopoulos Treatment Facility. Periodic reviews of the placement of civil involuntary and voluntary patients on the Xanthopoulos Treatment Facility will be conducted to ensure that patients do not unnecessarily remain on the Xanthopoulos Treatment Facility.

29. This recommendation is addressed in responses to recommendations 27 and 28.

30. The approaches utilized in managing this patient's excessive fluid intake are the most effective interventions of all those tried. Even with 1:1 staffing, it has not been possible to continually monitor his water intake. He is known to make numerous visits to the bathroom where he drinks from the sink and shower. He has been placed in seclusion for documented weight gains of eight (8) pounds or more between the hours of 10:00 A.M. and 7:00 P.M. and for altered electrolytes which can